

AFFIDAVIT OF UNREPORTED INCOME

Patient name: _____

Responsible Party name: _____ Relationship: _____

Account #: _____ Date of service: _____

I, _____ the undersigned, hereby attest to the following:

(patient / guarantor)

____ I have been receiving unreported income since _____.

(date)

____ My weekly gross income is \$ _____.

____ I am paid in cash.

____ My place of business is: Name: _____

Address: _____

Job title: _____

____ I am unable to provide verification of income because:

I attest that the information provided here is true and correct to the best of my knowledge.

Signature: _____

Date: _____