

# Request for an Extension on a Patient Responsibility Payment

Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

**Please be aware there is a non-refundable fee associated with this extension. See below for details.**

➤ Patient Name \_\_\_\_\_

➤ Patient Street Address \_\_\_\_\_

➤ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

➤ Patient Phone Number ( ) \_\_\_\_\_

➤ Type of Payment Due: (check all that apply)

θ Co-payment: Amount \$ \_\_\_\_\_ + (add a \$5 extension fee) = \$ \_\_\_\_\_

θ Co-insurance: Amount \$ \_\_\_\_\_ + (add a \$9 extension fee) = \$ \_\_\_\_\_

θ Deductible: Amount \$ \_\_\_\_\_ + (add a \$9 extension fee) = \$ \_\_\_\_\_

Total Amount Owed: \$ \_\_\_\_\_

➤ How long do you need to satisfy amount owed: \_\_\_\_\_ days

\_\_\_\_\_  
*Patient Signature*

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(for office use only)

Authorized by \_\_\_\_\_ Date \_\_\_\_\_

Reason for approval \_\_\_\_\_

Additional Penalties assessed: \$ \_\_\_\_\_

Date	Activity	Comments