Lingraphica®

Private Pay Request Form

Please provide as much information as possible. The financial information provided is used to calculate a discount based on our sliding scale.

I. Patient Name: _____ Patient Date of Birth: _____

Form completed by (Name & Relationship): _____

II. Shipping Address:

Requested Device:

☐ TouchTalk (10" tablet model) ☐ MiniTalk (8" tablet model) ☐ AllTalk (12" laptop model)

III. Itemize Monthly Household Income:

Family/Household size: _____ Number of dependents: _____

Patient's monthly Income: _____ Patient's employment status: _____

Additional monthly household income: _____

Relationship of additional income provider: _____

Total household monthly income: _____

IV. Itemize Monthly Household Expenses:

Medical Expenses (Insurance premiums, prescriptions, co-pays, etc.):

Mortgage/Rent: _____

Other (childcare, loan payments, etc.): _____

Total household monthly expenditures: _____

V. I hereby acknowledge that the information given herein is true and correct. I authorize Lingraphica to verify any information contained in this document for the sole purpose of assessing financial need.

_____ _____

Signature Date

DO NOT WRITE IN BOX: To be completed by Lingraphica personnel

This document was received on _____ (Date) By _____ (Name/Title)

Approved by: _____ (Signature)