

Patient Financing

- Low Monthly Payments
- No Pre-Payment Penalties
- No Credit Check
- Extended Payment Arrangements

Pay for the Care You Need

Don't let those medical expenses such as deductibles and out-of-pocket balances stop you from getting the medical treatment you need but can't afford to pay.

With a HealthFirst Financial payment plan, you can make monthly payments within your budget over a longer period of time.

Forks Community Hospital has partnered with HealthFirst Financial to give patients an affordable low interest option for resolving out-of-pocket costs.

 **Apply Today**

Contact Forks Community Hospital

To learn more about the financing options available to you or to find out if you qualify, please contact Forks Community Hospital at:

(360) 374-6271

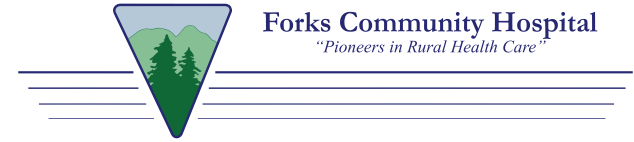
**530 Bogachiel Way
Forks, WA 98331**

Who is HealthFirst?

HealthFirst Financial offers a long term payment solution to patients who need a simple and convenient way to pay their medical expenses.

HealthFirst Financial partners with healthcare professionals nationwide.

www.healthfirstfinancial.com



A Plan For Every Patient

Monthly Payments You Can Afford



A HAWES FINANCIAL GROUP COMPANY

Low Interest Medical Financing



A HAWES FINANCIAL GROUP COMPANY

For more information, please contact Forks Community Hospital.

Application for HealthFirst Financing

Please mail the completed application to Forks Community Hospital

530 Bogachiel Way, Forks, WA 98331 | Phone: (360) 374-6271

Primary Applicant

Last Name	First Name	MI	SSN	DOB	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Address 2 (optional)	City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer Name	Employer Address	City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer Phone	Amount Requested	Desired Monthly Due Date			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Co-Applicant (if applicable)

Last Name	First Name	MI	SSN	DOB	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Address 2 (optional)	City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer Name	Employer Address	City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer Phone					
<input type="text"/>					

Signature of Applicant

(Please Do Not Print) Date

Signature of Co-Applicant (if applicable)

(Please Do Not Print) Date

Account Numbers

Write your Forks Community Hospital Account Numbers in the box below.