GATEWAY
DIAGNOSTIC IMAGING

Patient ID: _____

Written Attestation

Please complete the written attestation below as verification of how you meet your expenses.

Please Print:

Patient Name: _____
First Name Last Name

Patient DOB: _____
(mm/dd/yyyy)

I, _____ attest that my
(First Name) (Last Name)

current income is $_____ on a monthly basis. I affirm this to be true and further state

I have no supporting documentation regarding this income for the following reason(s):

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Center/Area Manager: _____ Date: _____

Director of Operations: _____ Date: _____