Center for Endoscopy, Inc.
3325 S. Tamiami Trail, Suite 100
Sarasota, FL 34239
Phone 941-552-3480 Fax: 941-552-3485

Financial Hardship Declaration

New [ ] Date:	Renewal [ ] Date:

INSTRUCTIONS

Patient/Legal Guardian – Complete Section 1. Please include copies of the most recent Federal Income Tax return or other proof of income for you and those in your household along with this application.

Healthcare Provider – Complete Section 2.

Incomplete requests cannot be considered and will be denied. Each request is subject to approval.

Section 1: PATIENT INFORMATION

Name (First): (Last): (M.I.):

Address:

City: State: Zip:

Date of Birth: Social Security #: US Citizen: [ ] Yes [ ] No

Marital Status: [ ] Single [ ] Married [ ] Widow [ ] Divorced [ ] Separated

Number of persons supporting household:

Number of persons dependent upon household income:

INSURANCE INFORMATION

If the patient does not have any public or private insurance, please check this box: [ ]

If the patient does have medical insurance or coverage of any kind, please indicate below:

Insurance Company: _____

Name of Insured, if other than patient: _____

Date of Insured's Birth: _____ Insured's Social Security #: _____

Address: _____

Phone: _____ Plan Name: _____

Policy ID Number: _____ Group Number: _____

Is the patient eligible for Medicare: [ ] Yes [ ] No If no, will the patient be eligible for Medicare within the next 12 months: [ ] Yes [ ] No If yes, please provide date patient will be Medicare eligible: _____ Medicare Policy # _____

Is the patient eligible for Medicaid: [ ] Yes [ ] No

FINANCIAL INFORMATION

Please include COPIES of the most recent Federal Income Tax return or other proof of income for you and those in your household. Please check this box if you do not file a return: [ ]

TOTAL ANNUAL INCOME (GROSS): $

Asset Valuation:

Value of Assets: $_____ Include: checking and savings accounts, certificates of deposit, stocks and bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash right now. Not included: your home, vehicles, or personal possessions.

Patient Authorization: I certify that I have provided my physician with all of the necessary consents authorizing him/her to release my health information to the Center for Endoscopy. Unless revoked, this authorization will remain in effect for the duration of my treatment.

Applicant Declaration Regarding Accuracy and Completeness of Information

I attest that the information on this form is correct and complete. If needed, the Center for Endoscopy may request and obtain additional information about my or my family's income. I agree with these terms by signing below.

Patient/Guardian Signature: _____ Date: _____

Guardian Name Printed: _____

Guardian Relationship/Contact Number: _____

Section 2: HEALTHCARE PROVIDER SECTION		
Provider Name:		
License #:	State:	
Business Name:		
Address:		
City:	State:	Zip:
Tax ID #:	Medicare Provider #:	
My signature below confirms that there is a valid medical need supported by documentation for this patient's treatment. Provider's Signature: _____ Date: _____		