VIZIA DIAGNOSTICS

Declined _____

Approved _____

Approver Signature _____

Approver's Name Printed _____

Date _____

Financial Hardship Application

Robert S. Smith, M.D., Inc. d/b/a Vizia Diagnostics

To be completed by Patient or Authorized Representative of Patient

Please complete the application and attached financial statement. Please return all forms and required documentation (by mail, fax, or email) to Robert S. Smith, M.D., Inc., 11390 Old Roswell Road, Suite 100, Alpharetta, GA, Attn: Billing Department; fax to 866-422-9032 or by email at pathologybillingdept@viziadx.com

All information relating to financial hardship requests will be kept confidential.

Patient Name: _____

Address 1: _____

Address 2: _____

Telephone #: _____

DOB: / / SS #: _____ _____ _____ _____

Date of Service: / / Alternate Date of Service: / / _____ _____ _____

Name of Person completing this Application (*if different than patient listed above*): _____

Telephone #: _____

Relationship to Patient: _____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): _____

Check Here if UNEMPLOYED. HOW LONG? _____

PLEASE LIST ALL CURRENT EMPLOYERS: _____

Employer 1: _____

Address: _____

Contact Person: Telephone: _____ _____

Employer 2: _____

Address: _____

Contact Person: Telephone: _____ _____

Please provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

¾ W-2 withholding statements or unemployment check stubs for the past 90 days

¾ Paycheck stubs for the past 90 days for all persons employed in the home
¾ Income tax return (most recent signed 1040 and/or W-2)
¾ Proof of all other income received in the past 90 days
¾ Application Forms from Medicaid or other State-funded medical assistance program
¾ Forms from employers or welfare agencies.

Patient has other circumstances that indicate financial hardship. These can be situations such as

(check all that apply):

¾ Proof of all outstanding debts or bills (copies of bills, statements; late notices, etc.)
¾ Proof of bankruptcy settlement (if applicable)
¾ Catastrophic situations (death or disability in family, divorce) or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses

Please describe why you need financial assistance:

_____

_____

_____

MONTHLY FAMILY INCOME & SOURCE

	Patient	Spouse	Dependents
Monthly Salary (Gross)	$_____	$_____	$_____
Public Assistance Benefits	$_____	$_____	$_____
Unemployment Benefits	$_____	$_____	$_____
Social Security Benefits	$_____	$_____	$_____
Workman's Compensation	$_____	$_____	$_____
Child Support	$_____	$_____	$_____
Other (Alimony, Etc.)	$_____	$_____	$_____
Subtotal:	$_____	$_____	$_____
TOTAL FAMILY INCOME	$_____	$_____	$_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE ROBERT S. SMITH, M.D., INC. TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____ ____/____/____

Signature of Person Making Request Date Date

_____

Printed Name of Person Making Request