

**Financial Verification Form**

**Patients to fax completed form and proof of income to (407) 370-3028**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Age: \_\_\_\_\_  
Surgery Date(s): \_\_\_\_\_

Procedure description: \_\_\_\_\_

- |   |  |                                     |
|---|--|-------------------------------------|
| <b><u>Are You?</u></b>                    | <b><u>Are You?</u></b>                   | <b><u>Are You?</u></b>              |
| <input type="checkbox"/> Married          | <input type="checkbox"/> Homeowner       | <input type="checkbox"/> Retired    |
| <input type="checkbox"/> Widowed / Single | <input type="checkbox"/> Renter          | <input type="checkbox"/> Employed   |
| <input type="checkbox"/> Separated        | <input type="checkbox"/> Boarder         | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Divorced         | <input type="checkbox"/> Assisted Living |                                     |

Number of dependents, including yourself? \_\_\_\_\_

**Monthly Household Income**

Earnings from Employment	\$
Earnings from Unemployment Compensation	\$
Earnings from Workers' Compensation	\$
Earnings from Social Security Administration	\$
Earnings from Child Support/Alimony	\$
Earnings from Pension or Retirement	\$
Earnings from Rental Real Estate	\$
Earnings from spouse or other household members	\$
Earnings from other income not listed above _____	\$
<b>Total Monthly Income</b>	<b>\$</b>
	<b>X 12 months</b>
<b>Total Annual Income</b>	<b>\$</b>

**List Primary Insurance Coverage / Comments below:**

- 
- I certify that everything I have stated on this financial verification form and any attachments are correct.
  - I certify that I am a US citizen and resident in the state in which the ASC resides.
  - I understand that I must update this information if any financial condition changes.
  - The falsification of data may result in the reversal of any adjustments.
  - This agreement is good for 90 days and is applicable for all dates of service within 90 days of the original date of service.

\_\_\_\_\_  
**Patient or Authorized Party Signature** \_\_\_\_\_  
**Date**

**Please note: In order to qualify for a Financial Hardship adjustment, you must provide proof of last three (3) months household income (pay stubs, tax returns, social security pay stubs, etc) and any valid insurance information.**

**Center staff to fax completed form along with proof of income to (407) 370-3028**

**Facility Use Only**

Approved \_\_\_\_\_ Discount % \_\_\_\_\_

Denied \_\_\_\_\_ Reason for Denial \_\_\_\_\_

Appealed ( ) Yes ( ) No

Approved after Appeal \_\_\_\_\_

Denied after Appeal \_\_\_\_\_

Regional Vice President \_\_\_\_\_  
(Signature)

Facility Administrator/ ASC Director \_\_\_\_\_  
(Signature)

Business Manager \_\_\_\_\_  
(Signature)