Acūtis

Financial Disclosure **Assistance Application**

Patient Name: _____ Telephone Number: _____

Address: _____ Patient Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Accession Number (s): _____

Please complete all information accurately. The signature of the patient or patient's guardian is required. Please make sure to attach the required supporting documentation.

Marital Status (Check one) ☐ Married ☐ Single ☐ Separated Total # in Household:

Dependent Name(s)	Dependent Date of Birth

Patient/legal guardian's monthly household resources:

Employment Income (per year): _____

Patient/Guarantor Employer: _____

Gross Monthly Income Amount: _____

Other Income Source and Gross Monthly Amount: _____

Total Annual Gross Household Income: _____

Insurance Verification

1. Do you have Health Insurance? ☐ Yes ☐ No
   a. Insurance Company Name: _____
   b. Address: _____
   c. Member ID: _____
   d. Other Source: _____

I certify that the information provided is true and to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws.

Proof of income is required before any consideration is made. Acceptable proof of income can be (but is not limited to the following): a copy of a paycheck stub, a copy of the previous year's tax return, verification of unemployment from the US Department of Labor, or a letter from your employer stating your present salary.

Patient Name (Print): _____

Guardian Name (Print): _____

Responsible Party Signature: _____ Date: _____

Please return the documents to the following address:

Acutis

Attn: **Billing Department - 400 Karin Lane - Hicksville, NY 11801**

For Office Use Only

Patient Name: _____ DOB: _____

Staff evaluating financial hardship form: _____

Date of processing: _____

Patient approval status: ☐ Yes ☐ No

If no, reason for denial: _____

If Yes, at what % rate: ☐ 100%. ☐ 75% ☐ 65% ☐ 60% ☐ 50% Other: _____

If other, please, explain: _____

Start Date of Service: _____ End Date of Service: _____

Authorized name: _____

Authorized Signature: _____

Thank you for continuing to be a valued partner of Acutis.