



Central Utah Clinic, PC

Your Health, Your Choice.SM

Financial Consideration Request

Patient Account # _____

Dear Patient:

We are aware that the cost associated with the care that you need may cause a financial burden that exceeds your means to cover it. We do not wish to cause our patients this type of situation and can possibly assist you by referring you to Health Clinic of Utah, reducing your amount owed or by writing off part of your balance owing. In the past few years, however, the health care industry has been vigorously scrutinized and, as a result, many regulations have been put in place to ensure that physicians do not discriminate or inappropriately provide financial benefits or incentives to patients for their services. Therefore, we ask that you please provide us the following information that will help us meet the requirements we have in documenting our compliance with these regulations. Please understand, as we review your request, it may be necessary to request more detailed financial information. Thank you for your cooperation.

(INCOMPLETE FORM MAY RESULT IN APPLICATION DENIAL)

Date: _____ Home/Cell phone _____

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Patient: _____ SS# _____
If different from above

Treating Physician (s) _____

Insurance: _____ Address: _____

PolicyHolder: _____ Policy No: _____

Annual Income: \$ _____ Spouse's Income: \$ _____

Other Income: \$ _____ Source: _____

Verification of Income: _____

Employer: _____ How Long: _____

Address: _____ Phone: _____
Street City State Zip Code

Number of Dependents: _____ Age of Dependents: _____

Monthly Expenses:

House Payment/Rent: \$ _____ Charitable Contributions: \$ _____

Utilities: \$ _____ Medications: \$ _____

Phone: \$ _____ Food: \$ _____

Car Payments/Lease \$ _____ Miscellaneous/Other: \$ _____

\$ _____ \$ _____

Cable TV: \$ _____

Credit Card Payments: \$ _____ Total Monthly Expenses: \$ _____

\$ _____

\$ _____

\$ _____

Please complete other side

Please indicate the reasons why you are requesting financial assistance: _____

(Please use an additional sheet of paper if you need more space)

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

=====**Below is for office use only**=====

Referred to Health Clinics of Utah: _____ Date: _____

Reduce balance by: _____% Discharge balance of: \$ _____

Business Office Employee _____ Date: _____