Print Form


Dear Patient:

Thank you for choosing Eye Specialty Group for your health care needs. The Practice's Financial Hardship program is available to assist those patients determined to be in financial need, without regard to age, race, color, creed, sex, religion ancestry, marital status, disability or national origin. Eligibility is income-based. In order to process your Application for Financial Hardship, the following documents will be needed:

1. A completed request for Financial Hardship Application.
2. Verification of all income, such as a copy of your most recent paycheck, Social Security and/or governmental checks, pensions, child support check, etc.
3. A copy of your most recent Federal income tax return.
4. A copy of your most recent bank (checking and/or savings) statement.
5. If you are unable to work, please provide a note from your physician confirming your inability to work.

We have enclosed an Application for you to complete and return, along with the information requested above. It is important that we receive the completed Application and financial information within ten (10) working days. All applications for this program are subject to verification. If you provide false information, your Application will be denied and you will not be allowed to apply for the program in the future.

If your Application is denied, you will be notified by letter. At that time, you will need to call and set up an acceptable arrangements on your account(s). If your Application is approved, you will receive a letter notifying you of the approval with an explanation of the discounted amounts and exclusions. You will be responsible for any portion not discounted or not eligible for the Financial Hardship program. Hardship approval will remain effective for a period of twelve (12) months from the date of the approval letter. You must notify the practice of any changes in financial circumstances that could change your eligibility (new insurance or changes in income for example). A new application will be completed upon notification of any financial change.

Once you have completed the Application and gathered the required financial information, please call one of our patient account representatives to arrange an appointment to finalize the Application process.

Sincerely,

Cindy Brandon

ESG Patient Account Representative

foundation@esg.md 901-820-2256

Enclosure: Request for Financial Hardship Application

EYE SPECIALTY GROUP
Your Vision Partner

# PATIENT FINANCIAL HARDSHIP APPLICATION 2018

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for discounts, delayed payment plans or forgiveness of debt based on individual circumstances. To do this, we must ask for certain financial information. *All information will be held confidential according to our privacy policy.* Please provide the applicable documents listed below for **each adult family member** and return this application to **Patient Account Representative** at **Eye Specialty Group within 10 business days**. If you have any questions please call the business office at 901-820-2261.

- Copies of the two most recent payroll stubs, unemployment benefit payments or Social Security Benefits letter.
- Copy of the most recent IRS tax form (1040 and/or W-2)
- Copy of your most recent Bank Statement reflecting your Direct Deposit.
- If you are unable to work, please provide a note from your physician confirming your inability to work.
- **Copy of letter from your state Medicaid agency that medical assistance has been applied for and denied must be provided**

Patient name: _____ Patient date of birth: _____

Person Completing Form (if other than patient): _____

Name of other responsible party if applicable: _____ _____

Patient's Physical Address: _____

Mailing Address (if different than above):_____

Number of dependents in household: _____ Number of dependents in school: _____

Cell Phone: _____ E-mail: _____

## Employment/unemployment information (for each adult family member) if more than two adults please list on a separate sheet of paper and attach.

**Patient's** Employer: _____Employer Phone #: _____

Address of Patient's Employer: _____

Name of **Additional Adult Living in Home**: _____

Name of Additional Adult's Employer: _____Phone:_____

Address of Add'l Adult's Employer: _____

If unemployed, please state when employment was terminated. If lay-off is temporary, indicate expected duration:

_____

EYE SPECIALTY GROUP
Your Vision Partner

# PATIENT FINANCIAL HARDSHIP APPLICATION 2018

**Assistance received by Adult Members of Household**

- ☐ State financial assistance
- ☐ WIC
- ☐ Food stamps

| **Income:** | **Total Monthly:** | **Total Yearly:** |
|---|---|---|
| Wages (self) | $_____ | $_____ |
| Wages (spouse) | $_____ | $_____ |
| Other (describe) _____ | $_____ | $_____ |

**Are you (the patient) currently out of work?** ☐ Yes ☐ No

If yes, do you anticipate going back to work in the next six (6) months? ☐ Yes ☐ No

If yes, when? _____

Public Assistance:

A. Have you applied for Medicaid or other public assistance? _____
B. Please identify/describe:_____
C. What was the approximate date of your application? _____
D. What response have you received? _____

Other Available Health Care Coverage and Benefits:

A. Have you exhausted all other available health care coverage and benefits? _____
B. Please identify/describe:_____

EYE SPECIALTY GROUP
Your Vision Partner

**PATIENT FINANCIAL HARDSHIP APPLICATION 2018**

I hereby request that my Application for Financial Hardship be reviewed by Eye Specialty Group. I understand that the information submitted herein is subject to verification by the practice and therefore may need to be disclosed to a third-party for such purposes. I also understand that if the information that I have submitted is determined to be false, it will constitute fraud. Such a determination will result in denial of any Application and I will be liable for charges for services provided.

By signing below, I acknowledge that I have read this Application and understand the terms and conditions contained herein. I also understand that the completion of this form does not guarantee discount, payment plan or forgiveness of debt.

_____ _____

Signature (Patient) Date

_____ _____

Signature (Parent/Legal Guardian if Patient < 19 yrs old) Date

Patient Name: _____ MRN:_____

FOR ESG USE

Approved: _____ Denied: _____

Signature: _____ Date: _____

Printed Name: _____

Renewal Date: _____

Approval for Dates of Service From:_____ Thru: _____

Comments:

_____

_____

# Photography and Social Media Consent

Patient Name:_____Date:_____

I hereby give my consent to have medical photographs and/or videos taken of all treated sites for diagnostic purposes and to accurately document the medical record in the usual and customary manner. I agree that these photographs/videos may be used for teaching or marketing purposes or publication in scientific journals. It is specifically understood that in any such publication or use, I shall not be identified by name and every effort would be made to conceal my identity. I understand that refusal to consent in no way affects the medial care received.

By signing this form below, I confirm that this consent form has been explained to me in terms which I can understand.

(  ) I consent for these photographs/videos to be used in medical publications, medical journals, textbooks, electronic publications, and social media. I understand that in addition to medical professionals that the general public will be allowed to view the photo's in a before and after scenario. Although my identity will be concealed, it is still possible that someone may recognize me.

(  ) I agree to the use of my image for medical records *only.*

Patient Signature:_____Date:_____