



Premiere Surgical Specialists

General, Vascular, Trauma & Laparoscopic Surgery

Alvaro H. Devia, M.D., F.R.C.S.
Certified
American Board
of Surgery

Brian E. Juell, M.D., F.R.C.S.
Certified
American Board
of Surgery and
Surgical Critical Care

Thomas E. Rembetski, M.D.
Certified
American Board
of General and
Vascular Surgery

Declaration of Financial Hardship for Insured Patients

Patient's Name: _____ Acct#: _____ Balance: \$ _____

Social Security #: _____ Date of Birth: _____

Address: _____

Employer's Name: _____

Employer's Address: _____

Spouse's or Parent (if minor) Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____

Employer's Name: _____

Employer's Address: _____

By completing this form, you are stating that you or your family member is unable to make the required co-payments and/or deductibles as stated in your insurance policy. It may be necessary at any time for this form to be provided to your insurance company if they request an audit of payments collected by our office.

Total family income: _____ monthly or yearly

Total family expenses: _____ monthly or yearly

Total person (s) in family: _____

Are you eligible for Medicaid or local are welfare? _____ Yes _____ NO

If yes, what is your Medicaid ID number? _____

Is your current condition related to a claim under Workmen's Compensation, Automobile insurance or other liability insurance? _____ Yes _____ No

Do you have a secondary or supplemental insurance that may be responsible for this debt?
_____ Yes _____ NO

Do you have a guardian or other person who is responsible for your debts?
_____ Yes _____ No



In respect to your medical care, do you consider it possible in your current financial condition to pay the ordinary co-payment and/or deductible amounts which would normally be charged with the utilization of Medicare? _____ Yes _____ No

Please be sure to attach copies of your denial letter from Medicaid if applicable as well as your income verification. Your income verification needs to be ONE of the following:

- *Copies of three (3) consecutive months pay stubs.
- *Income Tax Returns for the year of or the year prior to the time of service.
- *SSI or SSD letter of approval (letter must show amount of monthly payment)
- *Copy of unemployment verification letter

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I WILL ADVISE THE MEDICAL OFFICE OF ANY CHANGE IN MY STATUS WHICH WOULD ALTER MY ANSWERS TO THE ABOVE QUESTIONS.

Patient Signature

Date

Witness

If you fail to complete this form you will be rejected. If you have any questions please call our office.



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Declaration of Financial Hardship for Uninsured Patients

Patient's Name: _____ Patient#: _____

By completing this form, you are stating that you or your family member is unable to pay the minimum payment required by law as applies to us as Medicare providers. It may be necessary at any time for this form to be provided to the government if they request an audit of payments collected by our office.

Total family income: _____ monthly or yearly

Total family expenses: _____ monthly or yearly

Total person (s) in family: _____

Are you eligible for Medicaid or local area welfare? _____ Yes _____ No

Is your current condition related to a claim under Workmen's Compensation, Automobile insurance or other liability insurance? _____ Yes _____ No

Do you have any insurance that may be responsible for this debt? _____ Yes _____ NO

Do you have a guardian or other person who is responsible for your debts?
_____ Yes _____ No

Please provide the following information for all of the members in your family who live in your home:

Name: Age: Relationship to you: annual Income:

If you reported zero income, please provide an explanation below:



Please be sure to attach copies of your denial letter from Medicaid if applicable as well as your income verification. Your income verification needs to be ONE of the following:

- *Copies of three (3) consecutive months pay stubs.
- *Income Tax Returns for the year of or the year prior to the time of service.
- *SSI or SSD letter of approval (letter must show amount of monthly payment)
- *Copy of unemployment verification letter

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I WILL ADVISE THE MEDICAL OFFICE OF ANY CHANGE IN MY STATUS WHICH WOULD ALTER MY ANSWERS TO THE ABOVE QUESTIONS.

Patient Signature

Date

Witness

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