Athens Spine Procedural Center, LLC
1550 Timothy Road, Suite 103
Athens, GA 30606-7836
(706) 850-5667 - PHONE
(706) 850-6249 - FAX

Financial Assistance Application

PATIENT INFORMATION Date: ________________

Patient's Name: ______________________________ Date of Birth: ________________ SS#: ________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: ______________________________ City: ______________ State: ________ Zip: ____________

Home Phone: ________________ Cell Phone: ________________ e-Mail Address: ______________________

Employment: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired

Residency Status: ☐ Citizen of the USA ☐ Georgia Resident ☐ Permanent Resident ☐ Other: __________

Do you currently have any type of health insurance? ☐ Yes ☐ No

Have you had your health insurance terminated in the past 3 months? ☐ Yes ☐ No

---

HOUSEHOLD INFORMATION

Total Household Size: ________________ Total # of Dependents: ____________ Total Household Income: ____________

ADDITIONAL INFORMATION

Explain any special circumstances that you would like us to consider when reviewing your application: ____________________

____

____

____

I would like to setup a payment plan for any remaining balance: ☐ Yes ☐ No

---

CERTIFICATION STATEMENT

- I certify that this form has been reviewed and is true and correct and that all income is reported to the best of my knowledge.
- I agree to provide any documentation requested to verify the statements provided and give permission for their agents to obtain.
- I understand that if I purposefully provide false information any approval may be reversed, and I would be responsible for the entirety of the balance.
- I understand that this information is being used for the determination of INDIGENT/CHARITY CARE for the services rendered at Athens Spine Procedural Center, LLC.
- I understand that my application will be denied if it is incomplete or I fail to provide any required documentation.
- If my financial situation changes, I will notify Athens Spine Procedural Center, LLC immediately.
- This document is good for one (1) visit to the Facility and expires six (6) months after approval date.

______________________________ ______________________________
Signature of Patient or Responsible Party Print Name

______________________________ ______________________________
Signature of Witness Witness' Name

****For Office Use Only***	
Recommendation: ☐ Indigent: Amount: __________% ☐ Charity: Amount: __________% ☐ Denied: Reason: ______________________	Reviewed by: ______________________ Date: ____________ Approved by: ______________________ Date: ____________
Date of Appointment: ______________ Encounter #: ________________ Amount of Financial Assistance: $______________	

Revised: 02/18/2020