Single Visit Financial Consideration Request

Date: _____ Physician: _____ Account Number: _____

Name: _____ Date of Birth: _____

Address: _____
Street *City* *State* *Zip Code*

Patient: _____ SS #: _____
If different from above

Insurance: _____

Address: _____

Policyholder: _____ Policy No: _____

Number of Dependents: _____ Monthly Income: $_____ $_____
You *Spouse/Other*

Monthly Expenses: $_____

Please indicate the reasons why you are requesting a balance reduction/write off:

_____

_____

_____

_____

Signature: _____ Date: _____

----------Clinic Use Only----------

****If ongoing treatment is required please indicate if the patient is to be referred to Health Clinics of Utah.***

YES NO Referral Date: _____ By: _____

Reduce balance by _____% Discharge balance in full _____

Physician Signature: _____ Date: _____

I certify that information listed above is true and correct to the best of my knowledge. Giving false information will nullify this agreement and payment will be due in full.

The Single Visit Consideration Request form must be filled out for each visit. The application must be signed by the patient and returned directly to the rendering physician's office for the physician(s) signature. All questions, including the approval or denial of the financial consideration request, must be made directly to the Physician's office where the services were received.