Initial Application

*Please Print*

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Clinic & Account Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Service: \_\_\_\_\_Clinic \_\_\_Emergency \_\_\_Inpatient

**\_\_\_\_\_\_OP Surgery \_\_\_\_Other**

|  |  |  |  |
| --- | --- | --- | --- |
| Address | City/State/Zip | Telephone # | Cell Phone or Other Contract (Name & Phone #) |
| Date of Birth | SS # (Optional) | Employer | Address / Phone # |
| If minor – Parent’s Names | SS # (Optional) | Employer | Address / Phone # |
| Family Members: | Dates of Birth: | SS # (Optional) | Family’s Annual Income |

Situational Information / Please describe you current financial situation / hardships:

**Applicant Statement:**

I certify that the above information is correct. I understand that the information, which I submit, is subject to verification by Richmond University Medical Center and subject to review. Further, I will take all steps necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.), which may be available for payment of my hospital charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. I understand that if any of the information I have given proves to be untrue, the hospital may re-evaluate my financial status and take whatever action it deems appropriate.

 Signature (Patient or Guarantor) Date

 Print Name Relationship to Patient