SPIVEY STATION SURGERY CENTER

Dear Patient:

Spivey Station Surgery Center is providing this application, because you may qualify for our Financial Assistance Program.

To be eligible for the program, you cannot be covered under a commercial or private insurance plan. You also cannot be eligible for Medicaid, State or Local Assistance.

The attached form only applies to this Surgery Centers bills involving medically necessary treatment. This does not include physician or lab charges.

In order to be considered for full or partial assistance, you must complete the Financial Assistance Application. The responsible party must sign the bottom, and return the completed application with at least two of the following documents.

(a) Supporting W-2
(b) Supporting 1099
(c) Most recent bank and broker statements
(d) One month's pay stubs

If for any reason, you cannot provide us with the requested documents, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our determination by letter. If you have questions or concerns, please feel free to contact our center at (770) 960-2701.

Sincerely,

Spivey Station Surgery Center

FINANCIAL ASSISTANCE APPLICATION

Patient Name_______________________________________ SS #______________________

Street Address ____

City ______________________________________ State________________ Zip____________

Date of Birth _______________________________ Phone #___________________________

Male or Female Referring Physician's Name____________________________________

Dependents in Household

(This includes spouse, children under 18 and all others claimed on your tax return)

Name (First, Middle and Last Name)	Age
____	_________
____	_________
____	_________

Employment (Patient/Responsible Party)

Employer Name____________________________________ Hourly Rate____________
Hours worked per week ___________
Current Gross Weekly, Monthly or Yearly Income (Before Taxes) __________________
If unemployed, date last worked ___________________

Other Income

	Patient
Social Security	
Pension	
Unemployment	
Worker's Compensation	
VA Benefits	
Rental Income	
Stocks, Bond, 401k	
Dividend/Interest	
Child Support	
Alimony	
Other	

Have you applied for Medicaid or any other State/County Assistance? _____________
If yes and known, Case Number _________________ Date Applied ________________

I, the undersigned, certify that the above information is true and correct to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report will be requested to verify information provided on this application. I understand that falsification of information submitted may jeopardize my consideration for the program.

Signature____Date________________

Kroll Background America

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT

(PLEASE PRINT OR TYPE)

I, the undersigned consumer, do hereby authorize Spivey Station Surgery Center (formerly DBA Surgery Center at Mt. Zion), by and through its independent contractor, **KROLL BACKGROUND AMERICA, INC. ("KBA")**, to procure a consumer report on me.

These above-mentioned reports may include, but are not limited to, information as to my character and general reputation discerned through employment and education verifications; personal references; personal interviews; a social security number verification; present and former addresses; criminal and civil history/records; any other public record.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to **KBA**, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681et. seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to Spivey Station Surgery Center, by and through **KBA**, including, but not limited to, any and all courts, public agencies, and law enforcement agencies regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release Spivey Station Surgery Center, **KBA** and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative consumer report hereby authorized. I understand that this Authorization/Release form shall remain in effect for the duration of my employment with said Company.

Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application or employment will be terminated based on any false, omitted or fraudulent information.

Signature: ____

Printed Name:_____________________________________ Date: ______________
First Middle Last

Current Street Address: ______________________________________

City/State/Zip ______________________________________

Former Street Address: ______________________________________

City/State/Zip ______________________________________

Former Street Address: ______________________________________

City/State/Zip ______________________________________

Social Security Number: ________________ Daytime Telephone Number: ____________________

Driver's License Number: __________State of Issuance: ____Date of Birth*: ________ Gender*______

- Have you ever been convicted of a crime or convicted in a military court martial? Yes____ No____
- Have you ever been sanctioned or had your licenses suspended or revoked? Yes____ No____
- Are you currently under any investigation or pending charge? Yes____ No____