

No-Cost Screening Colonoscopy Request Form

Patient Information

Name _____ Account # _____

Date of Birth _____ Date of Application _____

Address _____
APT # STREET CITY STATE ZIP

Telephone # _____ Social Security # _____

Complete the Questions below:	Yes	No
Have you ever had a screening colonoscopy?	_____	_____
Do you have health insurance?	_____	_____
Date last covered by insurance? _____		

Please attach a copy of termination letter from your insurance company.

(Please note, if you have health insurance please call 336 768-6211 and speak to our billing department)

Estimated annual income \$ _____

As a result of the recent loss of my employment and health insurance, I don't currently have the financial resources to pay for a screening colonoscopy. I hereby request to be considered for the no-cost screening colonoscopy provided by Digestive Health Specialists, PA.

I certify that the above information is true and accurate to the best of my knowledge.

I understand that this application is made for Digestive Health Specialists, P.A. to judge my eligibility for financial assistance. If financial assistance is approved, I understand that Digestive Health Specialists, P.A. may verify any of the above information and I grant my permission for such verification and agree to assist in any way requested. If any information I have given proves to be unsupported, I understand that Digestive Health Specialists, P.A. will re-evaluate my financial ability and the full amount of my bill may become due and payable.

Patient Signature

Date

Fax this form to 336-397-5200 when completed