TRIUMPH RADIOLOGY

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FINANCIAL HARDSHIP CONSIDERATION FORM

Triumph Radiology has established a policy of screening requests for discounts from charges or forgiveness of debt based on individual financial hardship circumstances. Please complete this form to the best of your ability:

Patient Name:_________________________________ Date of Service:____________

Type of Exam:____

This is a request for Triumph Radiology to reduce my balance.

Please outline the reason for hardship:

____

By signing below, I certify that the information on this form is accurate to the best of my knowledge.

Patient Signature:__________________________________ Date:_________________

Signature of parent or guardian, if applicable:___________________________________

For Triumph Radiology staff only:

Action to be taken:

{ } Write off balance in full.
{ } Deny and expect payment in full.
{ } Reduce payment and ask for remainder in full.
{ } Bill insurance and write off patient responsibility
{ } Employee
{ } Other____

Supervisor Signature: ___________________________________ Date:___________