Applied Diagnostics

Application for Financial Hardship

At Applied Diagnostics we believe that peace of mind is an important part of the healing process. As such, we are committed to working with physicians and patients to make these important tests available and affordable. This is an ongoing effort that is supported by our belief in our mission and values. To request an adjustment on your account for reasons of financial hardship please answer the following questions:

PATIENT NAME: _____ Date of Service: _____

ACCOUNT NUMBER: _____ Remaining Balance: _____

1) Number of family members in household supported by above income: _____

2) Total annual gross household income*: $_____

**Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.), Other Income.*

3) Any patient applying for financial hardship discount should provide the following documents:

- Copies of the last 3 payroll check stubs (or copies of unemployment, disability payment stubs, etc.)
- Copies of the last 2 month's bank statement
- Copy of previous year's tax return
- Proof of dependent's identity (e.g. Birth Certificate, if patient is a minor)

4) $ _____ Household net-worth, excluding home?

5) (Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

_____
_____
_____
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I HEREBY ACKNOWLEGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE APPLIED DIAGNOSTICS TO VERIFY ABOVE INFOMRATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY, I WILL BE NOTIFED AND APPLIED DIAGNOSTICS WILL BILL ME. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING.

_____ _____/_____/_____
PATIENT SIGNATURE DATE

_____ _____
SIGNATURE IF PATIENT IS UNABLE TO SIGN RELATIONSHIP TO PATIENT

_____
REASON PATIENT IS UNABLE TO SIGN

Please send this form back to:

Applied Diagnostics
ATTN: Billing Department
1140 Business Center Drive Suite 370
Houston, Texas 77043
Fax 713-271-6885

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FOR OFFICE USE ONLY

DATE: _____/_____/_____ REQUEST APPROVED ☐

REQUEST DENIED ☐

Account Number	DOS	Owed Amount	% Approved	Adjusted Amount	Denial Reason

REQUESTED BY: _____

APPROVED BY: _____

APPROVAL SIGNATURE: _____

TITLE: _____ DATE: _____/_____/_____