TRUE HEALTH DIAGNOSTICS

Financial or Medical Hardship Application and Agreement

True Health Diagnostics LLC ("True Health") understands that medical expenses can place great strain on patients, and believes that a patient's physical health should not be dependent on a patient's financial situation. This Financial Hardship Application is used to assist True Health Diagnostics LLC ("True Health") in determining your eligibility for a waiver of out-of-pocket medical expenses owed to True Health. Please ***complete*** *all of the requested information on this form,* ***sign*** *at the bottom, and* ***return*** *the signed form and supporting information to True Health by mail or fax, to one of the following:*

Mail	Fax
True Health Diagnostics LLC Attn: Billing Customer Service 737 N. 5th Street, Suite 103 Richmond, Va. 23219	888-551-8167

If you have any questions, please contact the Billing Customer Service Department at (877) 443-5227, and select option 1.

PERSONAL INFORMATION

Patient's Name: Last, _____ First, _____ Middle, _____

Date of Birth: _____

Other Person(s) or Legal Entities Responsible for Patient's Debt (include any insurer, parent of a minor child, etc.): _____

Relationship to Patient: _____

Name of Patient's Spouse: _____

Date of Service: _____

Patient/Household Address: _____

Patient/Household Tel #: _____

EMPLOYMENT INFORMATION

Name of Patient's Employer(s): _____

Patient's Employer(s) Address (es): _____

Patient's Employer(s) Tel #(s): _____

Spouse's Employer(s): _____

Spouse's Employer(s) Address (es): _____

Spouse's Employer(s) Tel #(s): _____

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HOUSEHOLD INFORMATION AND INCOME

Number of People in Household:_____

Household Member	No.	Annual Income	Monthly Income
Self	1		
Spouse/Partner			
Children under age 21			
TOTAL INCOME		$	$

Income includes wages, unemployment compensation, workers compensation, social security, disability, supplemental security income/public assistance, veteran's payments, business or self-employment income, alimony, child support, rental income, interest or dividend income.

Please include copies of supporting documentation of income:

a) **W-2 withholding statements**
b) **Paycheck Stubs**
c) **Income tax returns**
d) **Certification/approval letters from Medicaid or other State-funded medical assistance or welfare agencies.**

OTHER CIRCUMSTANCES

Please certify any other circumstances that you believe impose financial hardship on you, such as:

a) **Copy of court order bankruptcy status.**
b) **Catastrophic personal situation (death or disability)**

CERTIFICATION AND AGREEMENT

I am making this application to enable True Health to determine my eligibility for a waiver of out-of-pocket medical expenses owed to True Health. I authorize True Health to verify any information contained in this document for that purpose. I certify that this information is true, accurate and complete in all material respects. If any of this information changes, I will inform True Health, and I understand that True Health may re-evaluate my financial status and take action necessary to collect on my account. If any third-party payor responsible for all or part of the cost of medical expenses owed to True Health contacts me, or if I otherwise am required, I will notify such payor of my application and of any waiver that True Health offers to me.

_____ _____

Signature of Patient or Other Legally Responsible Party

Date

_____

Relationship