FINANCIAL ASSISTANCE PROGRAM

Dear Valued Patient:

We are required by law to send invoices to our clients in an attempt to collect patient responsibility portions of all claims. We are pleased to offer a program that enables our patients to receive assistance with any remaining balance considered to be patient responsibility, once claims have been paid. If there is any additional information that you may provide us regarding a secondary or tertiary policy that may reduce this responsibility, please do not hesitate to contact our office. We will put forth our greatest efforts to reconcile any balance with this information.

If this is not an option for you, and you find yourself with a remaining balance that is creating a hardship for you or a loved one, you may apply for our Financial Assistance Program. We make the program available to our patients because we understand the cost of healthcare today may prevent you from acquiring the high-level of patient care you expect.

Gibson Diagnostic Labs strives to make this process simple and efficient. Please complete the attached application in its entirety. Do not leave any fields blank and provide us with as much household information as possible. You have our commitment that we will review your case and respond to you in a timely manner. Once completed, please submit the completed and signed application to our office via email to **billing@gibsondx.com**, by fax to **800.435.4057** or by mail to:

Gibson Diagnostic Labs
Attn: Patient Billing Department
813 N. O'Connor Rd.
Irving, TX 75061

If you have any questions regarding this program, please contact a Patient Billing Specialist at 210.200.8575, Monday through Friday, 9:00 am to 5:00 pm CT.

Best regards,
The Gibson Diagnostic Labs Billing Team

GIBSON™ DIAGNOSTIC LABS
813 N. O'Connor Rd. | T: 855.890.9581 | CLIA # 45D2095863
Irving, TX 75061 | F: 800.435.4057 | www.gibsondx.com

FINANCIAL ASSISTANCE APPLICATION

Patient Name

SSN

Address

Email

Phone

DOB

Marital Status:
- ☐ **Single**
- ☐ **Married**
- ☐ **Divorced**
- ☐ **Separated**
- ☐ **Widowed**

Gross monthly income	$
Number of household members dependent on the income stated above	
Number of dependent(s) currently attending school	
Annual tuition costs for the dependent(s) listed above	$
Monthly mortgage, rent or property tax payment	$
Monthly car payment(s)	$
Annual medical expenses not including the current bill	$

To apply for financial assistance, please complete this form and submit it with supporting documents to Gibson Diagnostic Labs via email to **billing@gibsondx.com**, by fax to **800.435.4057** or by mail to **Attn: Patient Billing Department- 813 N. O'Connor Rd. Irving, TX 75061**

Questions about completing this application or about supporting documentation required should be directed to the Patient Billing Department at 210.200.8575. Financial assistance is based on 400% of current Federal Poverty Guidelines.

To determine eligibility for financial assistance, a patient must complete this form and provide one (1) of the following documents:
- Most recent two (2) months' paycheck stubs;
- Previous year's W-2; or
- Unemployment or disability stubs for patient and/or guarantor.

If you wish to have additional financial obligations considered while eligibility is being determined, please provide as many of the following supporting documents:
- Copy of mortgage/rent/property tax payment or bill;
- Copy of monthly car payment or bill;
- Copy of tuition bill or written statement from institution verifying annual tuition amount; and/or
- Copy of current medical bills.

Patients who cannot afford to pay their bill are encouraged to request financial assistance prior to making payments to their account. Once a payment is made, received payments will not be refunded. If you do not qualify for a discount or a discount is not sufficient due to other circumstances, Gibson Diagnostic Labs will make every effort to develop a payment plan that works for you. Please call a Patient Billing Specialist to discuss at 210.200.8575.

I attest the information provided on this application is true, complete and accurate, and have attached documentation verifying household income indicated above. I agree, at any time during my enrollment, that Gibson Diagnostic Labs, LLC (the "Company") may request additional documents and verify all information submitted. I authorize the Company to bill any insurance/health coverage on my behalf and irrevocably assign any payment of benefits, claims, and rights to and direct payments be made to the Company. I also understand the Company reserves the right to change or discontinue this program at any time.

Signature of Patient (or Patient's Representative)

Representative's Relationship to Patient (if applicable)

Date