Patients Choice Laboratories

Patient Financial Assistance Program

The patient's insurance policy is a contract between the patient and his or her insurance company. That said, all charges are the patient's responsibility regardless of insurance coverage and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, Patients Choice Laboratories (PCL) submits claims to the patients' primary and secondary (if necessary) health plans and makes every effort to ensure that claims are processed.

PCL accepts cash, checks, money orders, debit cards and credit cards. If a patient can't pay a balance within 30 days, the patient should contact the billing department at **317-299-5227**. There are several ways you can pay your bill, including possible payment plans and a representative will help find the right one for your financial needs. PCL will also work with you to determine if you are eligible for financial assistance.

PCL Due Balances.
A due balance is any amount owed after the insurance company has paid its portion, but where PCL has not received the full patient balance within ninety (90) days. Balances on accounts with payment plans where payments are in compliance with the plan are not considered PCL due balances.

Payment Plans.
Payment arrangements may be made on patients' accounts based on a review of circumstances and approval by PCL. We generally do not extend payment plans to patients who have failed to make timely payments. PCL representatives may authorize monthly installment payments following the practice's minimum payment guidelines below (individual circumstances may vary):

Account Balance	Minimum Monthly Payment
$100 or less	$10.00
$250 or less	$25.00
$251- $500	$45.00
$501- $750	$65.00
$751- $1000	$85.00
Over $1,000	10%

Waiver of Co-Pays and Deductibles.
a. It is the policy of this laboratory to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. PCL will not waive co-pay, coinsurance, or deductible amounts for insured patients, except in the limited circumstances set forth in the Patient Financial Assistance Program. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be rare.
b. If PCL does waive co-payments or deductibles for a patient based on the patient's financial status, we will maintain a record of the information upon which we based this decision. Waivers

of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. PCL will maintain records of what collection efforts have been made for fees waived in these instances.

c. Under no circumstances will our laboratory engage in any of the following practices with respect to the waiver or lowering of co-insurance and/or deductibles:
- Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our Policy.
- Advertise, or in any way communicate to the general public that payments from payerswill be accepted as payment in full for healthcare services provided, or advertise or otherwise communicate to our patients or to the general public that patients will incur no out of pocket expenses.
- Routinely use patient assistance program forms which state that the patient is unable to pay co-
insurance and deductible amounts.
- Charge Medicare beneficiaries or private insurance beneficiary's different amounts than those charged to other persons for similar services.
- Fail to collect co-insurance and deductibles from a specific group of patients for reasons unrelated to indigence or managed care contracting (e.g., to obtain referrals or to induce patients to seek care in my practice vs. another provider's practice who does not waive co-pays and/or deductibles).
- Accept "insurance only" as payment in full for services rendered.
- Fail to make a reasonable collection effort to collect a patient's balance.

Patient Assistance Program.
a. For indigent, uninsured or underinsured patients, PCL may reduce or eliminate the patient's financial responsibility for medically necessary and appropriate treatment on a case-by-case basis where the patient qualifies under our patient assistance program guidelines.
b. Financial hardship determinations are based upon a review of household income, assets, and
liabilities in relation to current Federal Poverty Income Guidelines. As part of the process, we generally evaluate income levels, net worth, employment status, other financial obligations, the amount and frequency of healthcare bills, and other circumstances. Insured patients who choose not to have their claim filed with their insurance company are not eligible for our financial hardship assistance program.
c. Upon verification of a patient's financial hardship, the practice uses the below chart as a guideline to determine the level of discount.

Income Level:	
Over 3.00 x poverty level	No discount
2.5-3.00 x poverty level	40%
2.0-2.49 x poverty level	60%
1.5-1.99 x poverty level	75%
1.0-1.49 x poverty level	90%
0.0- 0.99 x poverty level	100%

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d. The determination of financial hardship is applicable to the current episode of care. To waive or reduce future payments, the patient must again prove financial hardship. The patient and the PCL representative shall sign a statement detailing that the practice has reviewed proof of financial hardship, and what bills are being reduced or waived.

Applying for Financial Assistance.

a. The patient or responsible party must complete the attached Patient Financial Assistance Program Application.

b. Submit the completed worksheet and be prepared to submit any supporting documentation (e.g., W-2s, Federal tax return, pay stubs, bank statements, proof of income, unemployment forms, other hardship approvals, etc.) to PCL for review.

c. We will review your package upon receipt and contact you if additional information is required. Applications will not be approved for patient financial assistance when required forms are incomplete or necessary documentation is missing.

d. We will contact you regarding your application, generally within 5-7 business days after we receive your complete application and all required attachments. The representative will inform you of our decision regarding your request for patient financial assistance and, if applicable, the level of discount for your outstanding medical bill with PCL.

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Financial Assistance Application

Our laboratory abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for discounts, delayed payment plans or forgiveness of debt based on individual circumstances. To do this, we must ask for certain financial information. *All information will be held confidential according to our privacy policy.* Please provide the documents listed below for each adult family member, and complete this form to the best of your ability:

• A copy of previous year's federal tax return;

• Copies of the two most recent payroll stubs or unemployment benefit payments;

Patient name: _____ Patient date of birth: _____

Your name: _____ Name of other responsible party: _____

Number of dependents in household: ___ Number in school: _____

Phone: _____

E-mail: _____

Type of assistance requested

( ) Reduced co-pay/co-insurance ( ) Discounted cash services ( ) Payment plan ( ) Debt forgiveness

Employment/unemployment information (for each adult family member)

Name: _____ Employer: _____

Address: _____

Phone: _____

Employer: _____

Address: _____

Phone: _____

Name: _____ Employer: _____

Address: _____

Phone: _____

Employer: _____

Address: _____

Phone: _____

If unemployed, please state when employment was terminated. If lay-off is temporary, indicate expected duration:

_____

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Assistance received

☐ State financial assistance ☐ WIC ☐ Food stamps ☐ CHIP

Property/investment values

	Address or description	Value
Home		$
Other real estate owned		$
Land		$
Business		$
Livestock		$
Savings/stocks/bonds		$
Other investments		$

Notes: _____

_____

Please complete the information in the following table based on average income and expenses over the last 12 months. For amounts paid annually, enter annual amount divided by 12.

Household financial information

Monthly income (after payroll deductions)		Monthly expenses (not including payroll deductions)	
Employment	$	Mortgage/rent	$
Unemployment/severance	$	Auto/transportation	$
Self-employment	$	Non-reimbursed work expenses (e.g., parking, tools)	$
Interest/dividends	$	Insurance (e.g., life,	$

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		homeowners)	
Pension/disability	$	Utilities (e.g., lights, water, gas)	$
Child support/alimony	$	Medications	$
Short-term disability	$	Childcare	$
Long-term disability	$	Credit cards	$
Rental income	$	Child support/alimony	$
Other income:	$	Personal property taxes (home, auto)	$
	$	Other expenses:	$
	$		$
Total average income	$	**Total average expenses**	$

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee discount, payment plan or forgiveness of debt.

Signed: _____ Date: _____

For Office Purposes Only

Reviewed by: _____ Date: _____

Approved for: _____