



*Patient Balance Must Be \$500 or Higher to Apply

PATIENT FINANCIAL HARDSHIP APPLICATION

PLEASE MAIL BACK TO OUR OFFICE AT
10415 Wallace Alley St
Kingsport, TN 37663

PATIENT NAME:

PATIENT ACCT #:

ACCOUNT BALANCE:

Paragon Anesthesia, P.C. (known as Paragon herein) abides by the contractual and legal obligations of health benefit plans to collect all 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, Paragon has adopted a policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. Please complete the following form to the best of your ability and provide the following supporting documentation: **APPLICATION WILL NOT BE REVIEWED IF WE DO NOT RECEIVE ALL ITEMS REQUESTED AND/OR IF ANY INFORMATION IS OMITTED. APPLICATION MUST BE RECEIVED IN OUR OFFICE WITHIN 15 DAYS.**

A copy of most recent year's tax return; (MUST BE SIGNED)

- If taxes were not filed, a IRS Verification of Non-filing Letter is required

Information from two recent payroll or unemployment benefit payments; for all persons employed in the home

If income is close to or below poverty level, denial of state medical assistance

Forms from employers or welfare agencies

Most recent two months bank statements

Attached copy of Driver's License or identification card for all adults.

All information will be held confidential as per Paragon privacy policy.

Patient Name: _____ DOB: _____ SS#: _____

Spouse Name: _____ DOB: _____ SS#: _____

Guarantor name(s): _____ Date(s) of service: _____

Number of dependents per guarantor household: _____ Number in school: _____ Household total: _____

Phone: _____ E-mail: _____



Type of Assistance Requested:

Reduced deductible _____ Reduced co-pay/co-insurance/Non covered _____

Discounted cash services _____ Payment plan extension _____

Employment/Unemployment Information (for **each adult** family member):

Employer name: _____

Address: _____

Phone: _____

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

Assistance Received:

State financial assistance _____ WIC _____ Food Stamps _____ Charity Care/other _____

Property/Investment Values:

Home _____ Other real estate owned _____ Land _____

Business _____ Livestock _____

Savings/stocks/bonds _____ Other Investments _____

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

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		Insurances (e.g. life, homeowners)	
Pension/disability		Utilities (lights, water, gas, trash)	
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:	



Total average income		Total average expenses	

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

Signed: _____ Date: _____

PLEASE DO NOT WRITE BELOW. FOR OFFICE USE ONLY

Received hardship letter from patient on: _____ (Letter attached)

Application Reviewed by: _____ Date: _____

Approved for:
 Discounted amount \$ _____ Forgiveness of debt \$ _____

Payment Plan.
 First Payment due on: _____

Monthly Payment \$ _____

Approved On: _____ By: _____