



\*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

**IF YOUR GROSS HOUSEHOLD INCOME IS \$30,000 OR OVER YOU WILL NOT QUALIFY  
FOR ANY DISCOUNTS**

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 last 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.

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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: \_\_\_\_\_

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**Type of Assistance Requested:**

Reduced deductible \_\_\_\_\_ Reduced co-pay/co-insurance/Non covered \_\_\_\_\_

Discounted cash services \_\_\_\_\_ Payment plan extension \_\_\_\_\_

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**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:

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**Assistance Received:**

State financial assistance \_\_\_\_\_ WIC \_\_\_\_\_ Food Stamps \_\_\_\_\_ Charity Care/other \_\_\_\_\_

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**Property/Investment Values:**

Home \_\_\_\_\_ Other real estate owned \_\_\_\_\_ Land \_\_\_\_\_

Business \_\_\_\_\_ Livestock \_\_\_\_\_

Savings/stocks/bonds \_\_\_\_\_ Other Investments \_\_\_\_\_

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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:	



<b>Total average income</b>		<b>Total average expenses</b>	

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**

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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: \_\_\_\_\_