Financial Waiver

Name ______________________________ DOB ________ Number in Household _____

Address ________________________________ City_________ St _____ Zip ___________

Email address __________________________ Social Security # ________________________

Phone ______________________ Phone 2 _______________ Phone 3 ___________________

Responsible Party____ Phone __________________

Gross Income _____________ Other Income ____________________________
(Pensions, child support, social security, child support etc.)

Insurance ____ Policy Number __________________

Phone __________________________ Group Number _______________ Effective Date __________

Your insurance company and applicable laws and regulations require all providers, including Transcend Medical, to make reasonable efforts to collect all out-of-pocket, co-payments, deductibles, co-insurance, and related beneficiary cost-share amounts ("patient responsibility"). By law, we must attempt to collect the patient responsibility, unless we determine, in good faith, that your payment of your patient responsibility would cause financial hardship.

By signing below, I acknowledge and agree that, to the best of my knowledge, the financial information provided above is an accurate statement of my financial status. Transcend Medical will rely on the information I provide to make a financial hardship determination. I understand Transcend Medical must review this request before a waiver of financial responsibility can be made. I further understand that if approved, I will be required to complete a new financial hardship application to qualify for additional hardship waivers, which may be in different amounts than approved for previous hardship waivers. I further understand that waiver of my financial obligation to Transcend Medical does not cover amounts deemed patient responsibility, due to non-compliance with insurance and/or physician requirements, willful breakage, or theft of equipment.

Patient Signature ____ Date__________

Responsible Party ____ Date _________

Company Reviewer ____ Date __________

Approved _______ Denied _________

Approved for _________________________________ Amount _________ Term _________