CLINICAL PATHOLOGY LABORATORIES
A Sonic Healthcare Clinical Laboratory

Information for patients

Patient Financial Assistance Application

Thank you for using Clinical Pathology Laboratories for your medical laboratory needs.

Clinical Pathology Laboratories recognizes that laboratory medicine can be very expensive and bills can become burdensome for patients with limited financial means. We have developed a system to determine eligibility for discounts on your lab bill.

Please fill out the attached form completely and return to the Accounts Receivable Department:

Clinical Pathology Laboratories, 9200 Wall Street, Austin, TX 78754
Attention: Settlements

Billing Email: settlements@sonichealthcareusa.com
Billing Fax: 512.807.1816

Please submit one of the following documents with the completed financial form:

- Photocopy of pay stubs for three months before the date of service for all working household members.
- A letter from an employer indicating a breakdown of gross income, by month, for two months before the date of service for all working household members.

OR

- Proof of income from previous year's Tax Return, current year W2, Social Security, Workers' Compensation, Welfare, Child Support, Disability, Unemployment Compensation, or Alimony for all adult household members.

Failure to provide documentation to verify income may result in denial of your assistance application. Applicants who do not meet the income guidelines may wish to inquire about payment plan options that are available. Questions concerning this program or the application process should be directed to our Billing Services Department at **800.411.2762** or **cplbilling@cpllabs.com**.

For additional information, please visit our website **www.cpllabs.com**

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Clinical Pathology Laboratories
Patient Financial Assistance Application

Date _____ Accession Number or Date of Service _____

Patient Last Name _____ First Name _____

License Number _____ Date of Birth _____ Marital Status _____

Address _____ City _____ State _____ Zip Code _____

Contact Telephone _____

Employer Name _____ Employer Phone _____

City _____ State _____ Zip Code _____ Current Monthly Income _____

Was the patient covered by any insurance, Medicare, Medicaid or any other medical assistance for the date of service listed above? **Y☐N☐**
If so, give policy name, number and address on the back of this form.

Please provide the following information for yourself and all dependents:
(All persons for whom you are financially responsible, living in the same house and related by blood, marriage or adoption) Use back of form for additional dependents.

Person(s) Per Household _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Years' Gross Income **$** _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Years' Gross Income **$** _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Years' Gross Income **$** _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Years' Gross Income **$** _____

I hereby authorize Clinical Pathology Laboratories to make any inquiries necessary to verify my eligibility for financial assistance. I understand falsification of this eligibility information will result in being responsible for all incurred charges and ineligibility for future financial assistance.

_____ _____
Signature Date

For internal use only:

Level _____ FPIL $w_____ Applicant Max $_____ Qualify _____%

Old Balance _____ New Balance _____

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