SIGMUND LABS

Dear Patient,

Thank you for your interest in our Patient Financial Assistance Program. So that we can determine your eligibility, please complete the attached application form, and return it to the correspondence address listed on your invoice, along with one or more of the required documents listed below:

- A copy of last year’s W2 form
- A copy of last year’s income tax return
- A copy of your most recent pay stub (s)
- A proof source indicating that you are eligible for local, state, or federal assistance programs.

Once we receive your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately two weeks for your application to be processed. Do not make any payments until you receive notification regarding the status of your request. Applying for acceptance into our Financial Assistance Program does not guarantee reduced charges.

If you have any additional questions or concerns, please do not hesitate to contact us. Thank you for using Sigmund. We look forward to serving you in the future.

WHO IS ELIGIBLE FOR PAYMENT ASSISTANCE?

Payment assistance is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: and
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and
3. Meet both the income and assets eligibility criteria listed below.

Persons in Family	Poverty Guideline	<200%	200-225%	225%-250%	250%-275%	275-300%
1	$14,580	$29,160	$32,805.00	$36,450.0	$40,095.00	$43,740
2	$19,720	$39,440	$44,370.00	$49,300.0	$54,230.00	$59,160
3	$24,860	$49,720	$55,935.00	$62,150.0	$68,365.00	$74,580
4	$30,000	$60,000	$67,500.00	$75,000.0	$82,500.00	$90,000
5	$35,140	$70,280	$79,065.00	$87,850.0	$96,635.00	$105,420
6	$40,280	$80,560	$90,630.00	$100,700.0	$110,770.00	$120,840
	Patient Responsibility	**0%**	**20%**	**40%**	**60%**	**80%**

If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered payment assistance.

Assets Criteria

Individual assets cannot exceed $7,500 and family assets cannot exceed $15,000. Should an applicant’s assets exceed these limits, he/she may “spend down” the assets to the eligible limits through payment of the excess toward the hospital bill and other approved out-of-pocket medical expenses.

SIGMUND LABS

Patient Financial Assistance Form

Patient Name: ____________________ Telephone Number: _______________
Address: ____ Patient Date of Birth: ____________
City: ____________________ State: ____________________Zip Code: ______________
Invoice Number(s): ____

Please complete all information accurately. The signature of the patient or patient's guardian is required.

Please make sure to attach the required supporting documentation.

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?
   a. Yes If answer is "Yes", you are financially responsible for payment.
   b. No If answer is "No", complete form below.
2. Is any source, other than the patient, legally responsible for the patient's medical bills (e.g., Medicaid, local welfare agency, guardian or other insurance program)?
   a. Yes
   b. No
   c. If answer is "Yes" list:

Insurance Company Name: ____________________
Address: ____________________
Member I.D.: ____________________
Other Source: ____________________

3. Patient/legal guardian's monthly household resources:

Salary	$____________________
Social Security	$____________________
Cash/Welfare Payment	$____________________
Family Contribution	$____________________
Income from Savings Accounts, CDs, etc.	$____________________
Other	$____________________
Total	$____________________

4. Number of family members in household: ____________________

I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I also authorize the release of all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified, and Sigmund will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Patient Name (Print): ____________________
Guardian Name (Print): ____________________
Responsible Party Signature: ____________________
Date: _________________________

Please return forms to:

Sigmund NJ LLP
78 John Miller Way
Suite 300
Kearny, NJ 07032