Health TRACKRx™

FINANCIAL DISCLOSURE FORM

AIT Laboratories, a HealthTrackRx company is committed to providing affordable healthcare. We may elect to waive all or a portion of your balance if we determine that such a payment would be a financial hardship for you. To assist us in determining if you have the ability to pay your account balance, please provide the information requested in this form. If you have any questions about this application, please contact AIT's Billing Department at (940) 435-0242.

NAME : ______________________ **PHONE NUMBER :** ______________

ADDRESS : ____

PEOPLE LIVING IN YOUR HOUSEHOLD

Name	Age	Relationship	Gross Monthly Income

If you need more space, please continue back.

Are you receiving any type of assistance from local, county, state or federal government agencies? If so, please describe this assistance:

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Do you have any health insurance that covers laboratory testing or other health services? If so, please list the names of these insurance companies and their policy numbers:

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Is a guardian or anyone else legally responsible for your medical bills? If so, please list this person's name, current address and phone number:

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LEARN MORE (940) 383-2223 PatientInquiries@healthtrackrx.com www.healthtrackrx.com

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What is your monthly net income from the following?

Type	Last 3 Months	Last 12 Months
Employment		
Social Security		
Retirement		
Investments		
Child Support		
Disability		
WIC/Food Stamps		
Other		
TOTAL:		

As a condition of receiving financial assistance, you are required to submit proof of income. This information will only be used to determine and/or verify your eligibility for financial assistance. We will not use it for any other purpose and will store it securely in accordance with applicable laws.

Please submit copies of documents with this application. Documents will not be returned.

Acceptable documents demonstrating proof of income include the following:

- Income tax returns
- W-2 forms
- Pay stubs
- SocialSecurity checks, unemployment, or other benefit payments for the past month
- Other proof as requested

By signing below, I certify that the above information is true and correct to the best of my knowledge and hereby request that AIT use this information to make a formal determination of my eligibility for financial assistance. I understand that the information I submit is subject to verification, and I give AIT permission to do so. I understand that if I submit false, misleading or incomplete information, my application will be denied and I will be financially responsible for all services provided.

PATIENT'S SIGNATURE ______________________________

DATE: ____________________

Please return the documents to the following address:
AIT Laboratories
1500 I-35 W
Denton, TX 76207
FAX: 866-473-1094

AIT ONLY
Approved
Denied
NAME: SIGNATURE: DATE: REASON FOR DENIAL (IF APPLICABLE):

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