FINANCIAL HARDSHIP WAIVER

In consideration of my particular medical needs and care expenses incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage, and with understanding that I am personally financially responsible for any and all medical charges regardless of any applicable insurance coverage, **I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:**

- ☐ Insufficient current income
- ☐ Without any or applicable insurance for treatment at this medical provider
- ☐ With applicable insurance but still medically financially harmed (see below)

More importantly, I declare that without following payment assistance, seeking for and continuing with medically appropriate and important health care would have been impossible for me or would make me financially harmed if I were forced to pay full charges for my medically necessary care expenses after I have already paid the provider for my portion of the bills, but my insurance improperly denied my claims. I also declare that I personally requested for such payment assistance only after I was fully informed of my important medical treatment options and the necessity of said treatment options solely based on my particular medical needs and availability of this provider Payment Policy:

> *By* Payment Waiver *we mean a policy developed and utilized by a healthcare provider to determine patients' financial ability to pay for services. By "financially harmed," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them financially harmed if they were forced to pay full charges for their medical expenses."*

While I request and designate my authorized representative to continue to submit any new claims/appeal any denied claims on my behalf, I specifically request under this payment waiver for the following indigent discount assistance for the remaining total balance on my account upon the exhaustion of the claims process**:**

Check all that you wish to be considered for:

- ☐ Waiving collection of deductible
- ☐ Waiving collection of co-pays/encounter fees
- ☐ Waiving collection of co-insurance
- ☐ Waiving collection of insurance denial: $_____

Patient's Signature _____ **Date**_____

Provider's Staff/Agent Signature _____ **Date**_____

Rise Community Hospital
37358 Market Place Dr.
Prairieville, LA 70769
P: (225) 755-9765 • F: (225) 778-8871