4path, Ltd.
8238 S. Madison Street
Burr Ridge, IL 60527
877-88-4PATH FAX: 630-780-4909

CHARITY CARE

REQUEST FOR WAIVED OR REDUCED PAYMENT

Please complete ALL information. Incomplete forms will not be considered.

This information will be kept in strict confidence and used only by 4path for the purposes of determining eligibility for payment reduction. Incomplete forms will NOT be considered and individuals will NOT be notified of incomplete forms.
Print all information legibly. ***FAX fully completed form to 630-780-4909 or mail to the address above.***

Name:_____

Address: _____

Phone Number: _____ E-mail:_____

Date of service:_____ Location:_____

Doctor Name (who did procedure): _____

Provide the following information:

Home: ( ) rent ( ) own ( )paid in full ( ) mortgage ( )behind in payments

Auto(s) : Number owned:_____ Newest Model and year:_____

Other medical bills outstanding (total, not including 4path): $_____

Other bills outstanding (total, not including mortgage): $ _____

Monthly income & assistance (all sources): $ _____

Health Insurance Provider: _____ ( ) no insurance

Provide copies of the following: (Required to be considered as complete application)

- Current Health insurance card(s)
- Copy of Driver's License with current address
- Current bill from 4path and past due notices (if any)
- We may request additional financial information and tax filings.

I understand that I am requesting reduction in the amount that I owe 4path, Ltd. a health care provider that has previously provided services to me for which I am financially responsible. I am requesting this reduction because I am ***unable*** *to meet these financial obligations. I attest that I do not have the financial resources to pay for these services, including financial resources of any spouse or life partner, whether or not we are bound by marriage, civil union or common law union. I attest that my statements of financial status are truthful and I am not requesting this reduction for any other reason other than true financial hardship. By this attestation I confirm that I do not have the financial means to fulfill this obligation regardless whether or not I have health insurance. I understand that my submission of this form does not guarantee reduction of my financial obligation. I understand that 4path cannot consider reduction requests by patients without completion of this form.*
I also understand that if I such attestation of inability to pay for these services is found to be fraudulent, 4path shall have the right to pursue any original outstanding obligation, including legal fees and damages. Misrepresentation of information may also be reported for criminal prosecution, where applicable.

_____ _____ _____
Signature of Requestor PRINTED NAME Date