NONA SCIENTIFIC LABORATORY

Complete Application Online

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 1601 NE 25th Ave. Suite 103 Ocala, FL 34470, along with **ONE** *or* more of the required documents listed below:

- A copy of last year's W2 form; or
- A copy of last year's income tax return; or
- A copy of your last two pay stub(s); or
- A proof source indicating that you are eligible for local, State, or Federal assistance programs

Or complete the online application at www.nonascientific.com/billing/#financial-assistance or use QR code on top right corner of this form.

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 Nona Scientific Laboratory. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service

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PATIENT FINANCIAL ASSISTANCE APPLICATION

Patient Name			
Address (City, State, Zip)			
Date Of Birth		**eMail**	
Date of Service		**Telephone Number**	

1. Does the patient have medical insurance coverage? YES ☐ NO ☐
2. If "Yes", please list the responsible party information: (Please include a copy of insurance card.)

Insurance Name		**Insurance Carrier Address**	
Policy Holder Name & ID:		**Insurance Carrier Phone #**	

3. Total annual gross household income*: $_____

   **Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Disability and Worker's Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance, Other Income*

4. Number of family members in household supported by above income: _____

5. (Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE *NONA LAB* TO VERIFY THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED, INCLUDING THE RIGHT TO SEEK SUPPORTING DOCUMENTATION FOR THE ABOVE REQUEST. I UNDERSTAND THAT IF I DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, I WILL BE NOTIFIED, AND *NONA LAB* WILL BILL ME.

Responsible Party Name (Print): _____
Responsible Party Signature: _____ *Date:* _____