PATHWAY GENOMICS®

Financial Assistance Program Application

A CAP and CLIA Accredited Laboratory | PO Box 101580 Pasadena, CA 91189-1580 | 877.505.7374 | www.pathway.com | clientservices@pathway.com

APPLICATION DETAILS

The Pathway Genomics Corporation Financial Assistance Program ("Program") is only available for those patients who (i) are uninsured, under-insured, or qualify as medically indigent; and (ii) meet the financial and medical requirements of the Program. Before granting financial hardship discounts or alternative payment arrangements, federal guidelines require us to make an assessment of the patient's financial condition. Financial hardship is the condition in which an individual is unable to provide the individual and the individual's dependents with adequate medical care without depriving the individual or the individual's dependents of food, clothing, shelter, and other essentials of living. By completing this form, Pathway Genomics Corporation (the "Company") will be able to determine if you qualify for a financial hardship arrangement. We will keep confidential the information you provide on this form unless disclosure is otherwise required by law. Payment plans for financial hardship are offered to eligible patients regardless of insurance status.

PATIENT INFORMATION (please print)

Patient Full Name:	Responsible Party Full Name:
Social Security #: DOB:	Social Security #: DOB:
Address:	Address:
City: State: Zip:	City: State: Zip:
U.S. Resident: ❑ Yes ❑ No	U.S. Resident: ❑ Yes ❑ No
Phone Number:	Phone Number:
E-Mail:	Relationship to Patient:

Additional Information to further explain your financial hardship:

Total # of members in household:

Patient's gross annual income: $
(Income before any and all taxes & deductions)

Suggested financial documentation:

❑ Tax Return ❑ Pay Stub ❑ W2

❑ Other (e.g. proof of government assistance)

VERIFICATION

I hereby certify, and would be willing to state under oath, that the information contained on this form is true and complete. I understand and agree that the Company reserves the right at any time and without notice to modify the application form; to modify or terminate this Program; and to audit the information I have provided on this application. I also authorize the release of any and all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified and Pathway Genomics Corporation will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

I fully understand that I am directly and fully responsible to the Company for the below-mentioned account(s) in payment for services rendered. I further understand that this agreement is made solely for the Company's additional protection and in consideration of the Company's allowing me to make monthly payments, authorizing a discount, or other financial consideration. In addition, I understand that should the account(s) be referred to a collection agency for collection of the balance, the discount on the remaining balance will be reversed and the full remaining amount will become due and payable.

Patient's Signature (required) **Date Signed (required)**

Guarantor's Signature Date Signed

For more information about Pathway Genomics Corporation
www.pathway.com | 877.559.1590 | billing@pathway.com

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The completed form must be faxed to 858.866.9751 or mailed to Pathway Genomics' Billing Dept. | 4755 Nexus Center Dr., San Diego, CA 92121