



## SUMMARY OF PATIENT PAYMENT OPTIONS



### Account Management Options:

To view your account activity or to update your information online, follow these simple steps:

- 1) Go to the internet site [www.peryourhealth.com](http://www.peryourhealth.com).
- 2) When prompted, enter the account number and password shown on your CellNetix invoice.

If you prefer to talk with a live person, or have any questions about your invoice, please contact our billing department at 1-800-374-4045.

\*We understand that life circumstances can cause unexpected financial difficulties for anyone. At CellNetix Pathology & Laboratories, it is our policy to work with our customers to reach a swift and compassionate resolution regarding financial concerns.

We ask that our patients contact our billing office by e-mail at [billing@cellnetix.com](mailto:billing@cellnetix.com) or at 1-800-374-4045, Monday-Friday, 6am-5pm, to initiate a conversation to resolve financial issues. Each case is reviewed on an individual basis, but in most instances, are resolved in one of three ways:

- 1) 25% discount for full payment of balance due to those who are uninsured
- 2) Payment plans for as long as six months
- 3) Charity care awards that match referring physician allowances, or based on proof of financial hardship

### Our billing office may ask that you:

- forward to us documentation showing your doctor's charity care award.  
OR
- fill out and return to us the CellNetix Confidential Financial Information Form (on the reverse side) and attach the following information:
  - Most recent signed IRS Tax Forms (1040 and W-2)
  - Check stubs for the past 30 days for all employed persons living in the home
  - Unemployment check stubs for the past 30 days (if applicable)
  - Proof of all other income received in the past 30 days
  - DSHS Denial Letter (if applicable)

Please mail the completed form and attachments to: Attn: Billing, 1124 Columbia Street, Suite 200, Seattle, WA 98104. Questions regarding the form or this process can be directed to the billing office at 1-800-374-4045, Monday - Friday, 6am-5pm or by e-mail to [billing@cellnetix.com](mailto:billing@cellnetix.com).

Once we receive this information, we will be able to make an assessment based on your specific situation. If documentation of your doctor's charity care award is not available, you will need to complete the CellNetix Confidential Financial Information Form; without it, we will not be able to make a determination.

**CELLNETIX PATHOLOGY & LABORATORIES  
CONFIDENTIAL FINANCIAL INFORMATION**

<b>FULL NAME:</b> (LAST) (FIRST) (MI)		
<b>ADDRESS:</b> (STREET) (CITY) (ST) (ZIP) (PHONE #)		
<b>DATE OF BIRTH:</b> (MONTH) (DAY) (YEAR)		
<b>OCCUPATION:</b>	<b>PRESENT EMPLOYER:</b>	<b>YEARLY GROSS INCOME:</b>
<b>SPOUSE'S OCCUPATION:</b>	<b>SPOUSE'S PRESENT EMPLOYER:</b>	<b>YEARLY GROSS INCOME:</b>
<b>BANK INFORMATION:</b> CHECKING ACCNT: \$ SAVINGS ACCNT: \$ OTHER ASSETS: \$	<b>DO YOU HAVE MEDICAL INSURANCE?</b> YES or NO <b>IF YES, LIST NAME OF INS CARRIER:</b>	<b>OTHER INCOME:</b> CHILD SUPPORT: \$ PENSION: \$ UNEMP/PUB ASSIST: \$
<b>YOUR RESIDENCE:</b> OWN or RENT	<b>RENT OR MORTGAGE MO PAYMENT:</b> \$	<b># OF DEPENDENTS INCLUDING SELF:</b> ADULTS: CHILDREN:
<b>PLEASE LIST CURRENT DEBTS OTHER THAN NORMAL HOUSEHOLD EXPENSES:</b>		
NAME OF CREDITOR	AMT OF PAYMENT/BALANCE DUE	ITEM PURCHASED
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
<b>TOTALS:</b>	\$	

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY CELLNETIX PATHOLOGY & LABORATORIES.

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_ DATE \_\_\_\_\_