CANCER GENETICS INCORPORATED

Indigent Patient Agreement

Patient Name: (Please Print Name)	
Patient's Date of Birth:	/ /
Patient's Social Security #:	- -

INDIGENT PATIENT AGREEMENT

This acknowledgment confirms that I have treated the indigent patient named above. My signature below verifies that this patient meets the definition of indigent as defined by the Department of Health and Human Services Poverty Guidelines and that the patient has no medical insurance coverage, including Medicare, Medicaid, private insurance, or other assistance program.

I have discounted my bill to the indigent patient, referred to in this acknowledgment form, at the rate of____%. I request that the laboratory discount billing for laboratory services for this indigent patient at an equivalent rate.

I hereby confirm that I will not pursue further collection on my bill for this indigent patient. I further agree to make available to the laboratory for inspection, upon request, my supporting documentation regarding indigent patients tested by the laboratory.

_____
Client Name

_____
Physician's Signature

_____
Date