FINANCIAL ASSISTANCE WAIVER AND PROSPECTIVE DISCOUNT PAYMENT AGREEMENT

This Financial Assistance Waiver and Prospective Discount Payment Agreement ("Agreement") is entered into as of this ____ day of _____ ("Effective Date"), by and between Lafayette Hospital and Clinics ("Hospital") and _____ ("Patient") (Hospital and Patient may be individually referred to herein as a "Party" and collectively as the "Parties").

WHEREAS, the Parties acknowledge and agree that Hospital has provided and may continue to provide patient care services to Patient in the future ("Services");

WHEREAS, Patient acknowledges that Patient may be eligible to receive the Services without charge or at a discounted rate under the Hospital's Financial Assistance Policy ("FAP"), a copy of which is attached as Exhibit A to this Agreement;

WHEREAS, Patient wishes to waive Patient's eligibility under the FAP to receive Services without charge or at a discounted rate and wishes to negotiate a flat fifty-five percent (55%) discount off the usual and customary charge for all Services rendered after the Effective Date of this Agreement (hereinafter, the "Discounted Rate"); and

WHEREAS, Hospital wishes to accept Patient's waiver of eligibility under the FAP and accept payment for Services rendered after the Effective Date at the Discounted Rate in accordance with the terms and conditions set forth in this Agreement.

NOW, THEREFORE in consideration of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration set forth below, the sufficiency of which is hereby acknowledged by the Parties, the Parties hereby agree as follows:

1. The Parties agree that Patient shall pay, and Hospital shall accept, payment for Services rendered after the Effective Date at the Discounted Rate off the usual and customary charge for said Services. Patient shall make payment in full within thirty (30) days of receiving the bill from the Hospital for the Services unless otherwise agreed to in writing by the Parties. For the avoidance of doubt, the Parties agree that the Discounted Rate shall not apply to Services rendered prior to the Effective Date. Patient acknowledges and agrees that, in the event Patient fails to make payment in full within the required time frame, Hospital may pursue Patient for payment in accordance with the Hospital's billing and collection policy.

2. Patient acknowledges that Patient may be eligible to receive the Services without charge or at a discounted rate under the Hospital's FAP. Notwithstanding said eligibility, Patient wishes to forego the FAP application process and hereby waives all potential rights and benefits that may be otherwise available to Patient under the FAP.

3. Hospital acknowledges that acceptance of Patient's payment for Services at the Discounted Rate, constitutes: (a) a full and complete satisfaction of any obligation Patient may have to Hospital related to the Services, including Patient's obligation to pay the total amount due,

as that term is defined above, and (b) a full release of any obligation Patient may have to the Hospital with respect to the Services, including the obligation to pay the total amount due.

4. Either Party may terminate this Agreement upon thirty (30) days advance written notice to the other Party. However, such termination shall not change or render void any payment obligation of Patient that accrued prior to the notice of termination, unless otherwise agreed to by the Hospital in writing.

5. This Agreement will be binding upon and inure to the benefit of the Parties and their respective successors and assigns. This Agreement constitutes the entire understanding and agreement of the Parties with respect to the subject matter of this Agreement, and supersedes all prior and contemporaneous understandings and agreements, whether written or oral, with respect to such subject matter.

6. No modification of this Agreement or waiver of the terms and conditions of this Agreement shall be binding upon the Parties to this Agreement, unless approved in writing by each of the Parties.

IN WITNESS WHEREOF, Patient and Hospital have each executed this Agreement as of the day and year first above written.

Hospital Date

_____ _____

Patient Date of Birth Date

_____ _____ _____

Dependent Name	Date of Birth	Gender*

Dependent Name	Date of Birth	Gender*

**Filling out gender is optional and not required for the patient or dependents*

EXHIBIT A

FINANCIAL ASSISTANCE POLICY

See Attached.