FINANCIAL ASSISTANCE WAIVER AND PAYMENT AGREEMENT

This Financial Assistance Waiver and 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 the following patient care services to Patient: _____ (collectively, the "Services");

WHEREAS, the usual and customary charge for the Services is $ _____ as evidenced by the invoice/bill attached hereto as Exhibit A (said amount being referred to herein as the "Total Amount Due");

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 B 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 pay Hospital the amount specified herein as consideration for the Services provided; and

WHEREAS, Hospital wishes to accept Patient's waiver of eligibility under the FAP and accept payment for the Services in an amount less than the Total Amount Due 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. Patient shall pay Hospital, and Hospital agrees to accept, in full satisfaction of the Total Amount Due, the compromised agreed amount of $_____ ("Agreed Amount"). Patient shall pay the Agreed Amount in full within thirty (30) days of the Effective Date unless otherwise agreed to in writing by the Parties. 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 of the Agreed Amount, constitutes: (a) a full and complete satisfaction of any obligation Patient may have to Hospital related to the Services as of the date of this Agreement, 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. Hospital hereby fully and forever releases and discharges Patient and Patient's successors or assigns from any and all claims, causes of action, liabilities or actions which in any way arise out of or relate to Patient's obligation to pay the Total Amount Due, whether now in existence or hereafter arising, in any manner whatsoever.

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 Signature: Date

_____ _____

Patient/Guarantor Signature: Date

_____ _____ _____

Patient Name: Date of Birth

_____ _____

EXHIBIT A

SERVICES INVOICE

See Attached.

EXHIBIT B

FINANCIAL ASSISTANCE POLICY

See Attached.