

Application: Reduction of Bill/Extended Payment Plan

Account Number _____

Patient Date of Birth _____

Patient Name _____

Address _____

Telephone _____

City _____

Email _____

State _____

Fax _____

Zip _____

Gross Monthly Income:

Self _____

Spouse _____

Other _____

Total _____

Number in Household _____

Monthly Household Expenses:

Mortgage _____

Rent _____

Insurance _____

Utilities _____

Car _____

Food _____

Medical _____

Other _____

Total _____

Patient or Guarantor Signature _____

Date _____

Final approval will require a copy of your most recent income tax return form accompanied by supporting W-2 or other wage verification. If you do not file a return, or if you have had significant financial changes, please explain on the back of this form. Return this form and all attachments to: NTD Labs, 403 Oakwood Rd., Huntington Station, NY 11746 Attn: Billing

We appreciate the opportunity to work with you to resolve your outstanding balance.