Patient Name: _____
MR Number: _____ Encounter ID: _____
Age:____ DOB:_____Gender: ____Svc Date:_____

Membership Application

Date / /

CARES representative _____

FIRST | LAST | Age | Gender | Orientation | Date of birth

Social Security | Drivers License | ETHNICITY | Race

Street Address | City | State: | Zip Code

ORLANDO | FL | 32806

Phone | ❑ Yes ❑ No Message | Email | ❑ Yes ❑ No Message

Emergency Contact | Phone ( ) - | Relationship | Type

Language | Interpreter

Reason for visit | Reason for visit | Reason for visit

Reason for visit | Reason for visit | Reason for visit

Employer | Type of work | How long | Hours

Insurance ❑ Yes ❑ No

Family Size

INCOME

3 bi weekly or 6 weekly only | Up to 3 entries

$0.00	$0.00	$0.00
Weekly	Monthly	Yearly

Monthly

FPL 0.00%

Entered so far $0.00 $0.00

Patient Name: _____ DOB: _____ MR number: _____

Bliss Cares 340b Program enrollment consent:

Bliss CARES is a Center for disease control (CDC) 340b covered entity. By participating in this program, as a patient, I understand that I could be eligible to receive assistance from Bliss CARES to cover expenses such as medication co-payments, office visit co-payments, and certain health care related deductibles. In order to be eligible, I agree that I will disclose my financial situation in it's entirety and undergo financial screening to determine eligibility by Bliss Cares, as requested by CDC guidelines. In addition I certify that my participation in this program is voluntary and is not an obligation in order to any services from Bliss Cares. At anytime I could be dis-enrolled from Bliss Cares 340b patient assistance if I chose to change medical practice.

Click here to sign

Patient Signature

Click here to sign

Bliss Cares Manager/Witness

_____

Bliss Cares Manager/Witness

Select Services

Client Pays

BLISS Cares Pays

Labs

Patient Name: _____
MR Number: _____ Encounter ID: _____
Age: ____ DOB: _____ Gender: ____ Svc Date: _____

Authorization to Obtain and Release Information

Member Name _____ S.S. _____ DOB _____ Gender ____

Address _____ City _____ State FL Zip Code _____

Phone _____

I hereby request and authorize: Bliss Cares Inc. 2901 Curry Ford Rd. Suite 106 Orlando FL. 32806
Phone: (407) 203-5984 Fax: (407) 386-8073

To obtain/release from/to the following:

The following types of information from my records:

- ❑ Medical Records
- ❑ Mental Health Records
- ❑ Substance abuse Records
- ❑ Income records
- ❑ Social Work/Case management records
- ❑ Legal or Power of Attorney
- ❑ Employment status
- ❑ other (Specify) _____

For the purpose of continuity and Coordination of Care

All information I hereby authorize to be obtained and released to and from the above named entity will be held strictly confidential and cannot be released by the recipient without written consent, This authorization also authorizes ***Bliss CARES*** and the above named entity to verbally discuss my case for the purpose of ensuring adequate coordination of my services, treatment and care. I also understand this authorization will remain in effect unless by me in writing. I understand that it is my right to revoke this authorization at any time.

I authorize the above named entities to (when necessary) correspond regarding my case through the use of:

- ❑ Postal Mail
- ❑ Fax transmittals
- ❑ Electronic Mail(Email)
- ❑ Telephone
- ❑ Text Messages
- ❑ In Person

All information I hereby authorize to be obtained and released to and from the above named entity will be held strictly
I understand and agree that ***Bliss CARES*** is not liable or responsible for any security risk associated with electronic, email or facsimile correspondence that my be intercepted erroneously by a third party.

This release will remain in force for one year unless revoked by member

Click here to sign
Signature

Click here to sign
CARES Representative

Patient Name: _____
MR Number: _____ Encounter ID: _____
Age: ____ DOB _____ Gender: ____ Svc Date: _____

Financial Assistance Application

BioReference Laboratories | genpath | GeneDx | Laboratorio Buena Salud
OPKO Health Companies

Please fill out this for in its entirety, and sign below.

Patient Name: _____

Patient Date of Birth: _____ Date of Service or Collection Date: / /

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Patient Phone Number: _____ Patient Number on the Bill: _____

As discussed, below is your Current Gross Annual Income and number of household members:

Gross Household Income: $ _____ Number of family members living in the household: _____

Federal Poverty Level Percentage (FPL): _____ %

Patient/Guardian Signature Click here to sign

Printed Name: _____ Relationship to Patient: _____

I attest that the information provided above is accurate. I understand that I am responsible to pay Bio Reference for any outstanding amounts due.

Please submit this form via any of the following options:

Mail to:
Bio Reference Laboratories
Attn: Billing Customer Service Dept.
481 Edward H. Ross Drive
Elmwood Park, NJ 07407

Email to:
BillingCS@bioreference.com

Fax to:
201-703-7130

NOTE:
You have 30 days from _____ to return the completed form, as instructed above. This form must be hand signed, prior to submission to the laboratory. If not received within 30 days, the reduced balance is no longer valid. You will not be eligible to re-apply for Financial Assistance for this specific date of service. Upon receipt, you will receive a statement of confirmation, including the new balance due. Additionally, we may require additional documentation if further clarity is needed.

Patient Name: _____
MR Number: _____ Encounter ID: _____
Age: ____ DOB: _____ Gender. ____ Svc Date: _____

Letter of Financial Support

Date _____

Re: _____ DOB _____

To Whom It May Concern:
The above-named patient/client is currently receiving financial support from me. In accordance with your eligibility criteria and to the best of my knowledge, this patient/client currently has zero income and is unable to afford to pay for essential services due to financial hardship.

I , _____ am currently providing the following;

- ❑ Room and Board with an estimated value of _____ at the below Address:

  _____ _____ ____ _____
  Street Address City State Zip Code

- ❑ Room only with an estimated value of _____ at the below Address:

  _____ _____ ____ _____
  Street Address City State Zip Code

- ❑ Cash _____ Monthly

- ❑ Other, specify _____

If you have any further questions, please call me at ( ) -_____

Thank you for your assistance.

Click here to sign

Support Signature

_____

Supporter Name