

[Date]

[Parent/Guardian Name]

[Address Line 1]

[City, State, Zip Code]

RE: Financial Hardship Application for [Patient Name]

Dear [Parent/Guardian Name],

We have reviewed your application for financial assistance regarding the medical care of [Patient Name]. We understand that medical expenses can be a burden, and we are committed to ensuring our patients receive the pediatric care they need.

We are pleased to inform you that your request for a hardship discount has been approved. Based on the documentation provided, you have been granted a [Percentage]% discount on your current outstanding balance and for qualifying services rendered over the next [Number] months.

Approved Discount Details:

- Current Balance Before Discount: \$[Amount]
- Discounted Amount: \$[Amount]
- Remaining Balance Due: \$[Amount]
- Approval Expiration Date: [Date]

Please note that this discount applies only to professional services provided by [Clinic Name]. It does not cover outside laboratory fees, imaging performed by third parties, or elective procedures not deemed medically necessary.

If you would like to set up a payment plan for the remaining balance, please contact our billing department at [Phone Number] or [Email Address].

We value the opportunity to care for your child.

Sincerely,

[Signature]

[Name of Billing Manager]

[Clinic Name]