INPATIENT AND OUTPATIENT FINANCIAL POLICY

Initials indicate that I, or my personal representative, have read and acknowledged the following information.

Thank you for choosing Legent Hospital as your health care partner. Our goal is to provide you with the highest quality surgical care at an affordable cost. We will disclose to every patient our Hospital charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your patient payment responsibilities. We ask that patients read the financial policy carefully and sign prior to any treatment. Initials indicate that I, or my personal representative, have read and acknowledge the following information.

1. We accept all Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA) and Flexible Spending Accounts (FSA).
2. All estimated patient responsibility is due at the time of service. If you are unable to pay the patient portion of your balance at the time of service, Legent hospitals offer access to Care Credit. Care Credit applications must be submitted and approved 24 hours prior to service. Contact the Patient Access Representative at the facility to request an application
3. We accept checks, all major credit cards, and Cashier's Check /Money orders. Dishonored checks will be charged back to the patient's account with a service fee of $10.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.
4. Failure to pay any outstanding patient balance within 120 days following statement mailing will result in your account being turned over to a collection agency. You will be responsible for any fees charged to us by the agency, in addition to your outstanding balance. We encourage you to communicate with our business office concerning any payment problems so that we may assist you in the management and payment of your account in order to avoid any collections placement.

Patient's Initials______________

ASSIGNMENT OF BENEFITS

We accept assignment of insurance benefits if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan applicable coverage or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this Hospital. However, you will be personally responsible for your account balance regardless of whether your insurance will pay for your total balance of your claims.

Please be advised that the eligibility and benefit information supplied by your insurance company is only an estimate and is not guarantee of payment by the insurer. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service.

Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. Our relationship is with you. **All charges are your responsibility whether your insurance company pays or does not pay.** Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, coinsurance, covered charges or secondary insurance coverage.

We are contracted with certain managed care plans and will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
We will verify your insurance coverage and your physician's office will obtain pre-certification if applicable for all services as a courtesy to you before your surgery. Please understand that all insurance verification and authorization is not a guarantee of insurance payment.

If a patient chooses or is required to bill his/her own insurance, this Hospital will provide an itemized statement to the patient but will treat the account as a self-pay.

Patient's Initials______________

Patient Identification Label

INPATIENT AND OUTPATIENT FINANCIAL POLICY

PHYSCIAN AND HOSPITAL CHARGES

All physicians furnishing services to the patient, including the, physician or other physicians, anesthesiologist, physical therapists and emergency department physicians, are independent contractors for the patient and are not employees or agents of the hospital and may bill directly for their services. Insurance requires your doctors, physical therapists and surgeons to charge and bill the services separately from surgical facilities or hospitals. You should expect to receive a separate bill in addition to the surgical hospital bill. If you have any questions about your doctor, physical therapist or surgeon bills, please direct your questions to that doctor's office.

While we do not anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions; you may incur additional expenses at this hospital and/or be transferred to another facility. **The Hospital Facility Fee only included the stated date of services at this Hospital and do not included any other date of service from us or other providers and/or facilities.**

Patient's Initials______________

YOUR RESPONSIBILITY FOR COOPERATION

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquires, request for additional information, claims status verification, or any inquires for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to the insurance company by you.

In the event that you do receive insurance payment checks for your surgeries rendered by your doctor, you agree to submit such insurance reimbursement check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance checks for the medical services from this Hospital, all your payment arrangement will be voided, and the total balance is due immediately. You further agree to compensate us for any legal fees if we must retain legal representation to collect past dues.

Patient's Initials______________

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation. Again, thank you for choosing Legent Hospital as your health care partner. We appreciate your trust in us, and we appreciate the opportunity to serve you.

ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The Financial Policy has been explained in detail to me. ☐Yes ☐No

I have asked any applicable questions concerning the Financial Policy for Legent Hospital. ☐Yes ☐No

I acknowledge that I am responsible for payment of any services rendered to me or my dependent. I understand the financial policies of the facility as outlined above. I authorize the facility to release information necessary to process my insurance claims (to both primary and secondary insurances).

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Patient Signature/Personal Representative

Relationship to Patient: ____________________ Date: ___________ Time: __________

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Witness Signature:

Date: ___________ Time:___________

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Second Witness Signature:

Date: ___________ Time: ___________ *(Required on Verbal Authorization)*

Patient Identification Label