CHESTNUT HEALTH SYSTEMS

PATIENT FINANCIAL AUTHORIZATION

Patient Name:		**Patient DOB:**
Responsible Party Name *(if not patient)*:		**Resp. Party DOB:**
Responsible Party Contact Information	**Phone:**	
Address:		
City:	**State:**	**Zip:**

The following outlines Chestnut Health Systems financial responsibility policy. This policy applies to all locations where services are provided. Staff will assist you in reviewing and explaining this form prior to your appointment. Please review each section carefully.

Payment Policy
If we are billing insurance or other payers on your behalf you will be responsible for any required copays, co-insurance and deductibles at the time of service. In the event you are self-paying for services, payment in full is expected at the time of service unless alternative arrangements are made with our business office.

Responsibility for Payment
Chestnut Health Systems participates with several major insurance companies as well as Federal, State and local payors. If you provide your current insurance card(s) and information at your visit we will bill your insurance company as a courtesy to you. We encourage every patient to understand their medical benefits. If you need further clarification, please contact your insurance company directly. Benefits quoted or services authorized by your insurance company do **not** guarantee payment for services. You will be responsible for any required co-pays, co-insurance, and deductibles identified by your insurance plan or other payers. Once your claim has been processed by your payer, any remaining balance will be billed to you.

If you have any financial obligation identified by your payer(s), you will receive an itemized statement identifying charges incurred and any payments received during the statement period and the amount due. Any balance due is payable in full **within 30 days** of receipt of such statement unless alternative payment arrangements are made with our business office.

Accounts not paid in full within **90** days are considered delinquent and may be assigned to a collection agency. If your account becomes delinquent and is referred to a collection agency, you will be responsible for any collection and/or legal fees assessed.

Assignment of Benefits
I authorize and direct that any insurance proceeds payable for services rendered by Chestnut, to me be paid directly to Chestnut and I hereby assign to Chestnut all interest in, and rights to claim, collect and receive, the proceeds from any insurance company providing coverage for these services. Any payments received by Chestnut from me or my insurance company may be applied to offset any balances in my account.

I confirm that I have been given copies of the following:

- ☐ Patient Financial Authorization Form *(this document signed and dated)*
- ☐ Chestnut Health Systems Sliding Fee Scale
- ☐ Chestnut Health Systems Payment Policy

Financial Assistance Determination:

Chestnut receives state and local funding to assist with the costs of treatment for individuals who do not have the means to pay for the full cost of services. To receive financial assistance, I understand that I must complete the fields below and provide the required supporting documentation.

I understand that if I qualify to receive assistance, the fees for services rendered to me will be based on a sliding scale and my proof of income or verification of unemployment.

If you do not wish to provide income information, check the box below:

☐ I understand that I am refusing to provide income information for purposes of determining eligibility for financial assistance. In doing so, I understand that I am forfeiting my right to financial assistance and will be responsible for payment of services not covered by my insurance.

Income Source:

☐ Employment ☐ Unemployment Benefits ☐ Pension ☐ Other *(specify):*

Income Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly **Total Household Income: $**

# of dependents including yourself:

Insurance Information:

☐ No Insurance/Self-Pay ☐ Medicaid ☐ Medicare ☐ Other*(specify)*:

My signature below indicates that the information provided above is true. I understand that if any of the above information is false, I will not be eligible for financial assistance and will be required to pay the full Chestnut fees. I understand that I have the right to review and copy the information I am permitting to be released.

Patient / Responsible Party Signature **Date**

Staff / Witness Signature **Date**

FOR OFFICE USE ONLY:

Proof of Income Documents Provided: ☐ Paycheck/Unemployment Stub ☐ W-2
☐ Proof Of Unemployment ☐ 1040 *(Tax Return)* ☐ Other: _____

Self-Pay Responsibility:	**Insurance** Copay/Coinsurance Resp *(Per Service)*:
Family Health Center: $	Family Health Center: $ or **%**
Mental Health/Substance Use: $	Mental Health/Substance Use: $ or **%**
Dental: $	Dental: $ or **%**