Acct # - _____

Patient - _____

MRN - _____

The Women's Hospital
JOINTLY PHYSICIAN OWNED
Deaconess

FINANCIAL RESPONSIBILITY

Thank you for choosing The Women's Hospital ("Hospital"). Our goal is to provide you with quality medical services. Your clear understanding of our financial policy is important to our professional relationship. Payment of your bill is vital to our ability to continue to provide medical care within the community.

ALL ACCOUNTS

In consideration of Hospital rendering services for the above named patient, I/we the undersigned, and each of us, agree to be jointly and severally responsible for payment for this hospitalization (including all services and fees) and any other outstanding account that the patient has with Hospital. Hospital will bill a patient's insurance company, and Hospital accepts all forms of payment for any amount not covered by insurance. I/we agree that the charges for which I/we are responsible will be calculated according to Hospital Chargemaster and I/we agree to pay those Chargemaster rates. All accounts are due and payable at the time of the patient's discharge. Any credit will be applied to outstanding balances prior to being refunded. Please contact the Hospital's Financial Counseling Services at 812-842-4240 if you need assistance. Past due patient accounts that do not have agreed upon financial arrangements with Hospital will be submitted to a collection agency or attorney for collection. I/we agree that I/we will pay all attorney fees and court costs incurred by Hospital in the collection of all sums due Hospital. If I/we provide Hospital or its agents with our cell phone number, I/we authorize Hospital or its agents to call/or text our cell phone either manually or by auto-dialer in order to collect any amounts I/we owe. I/we understand that any e-mail I/we provide is our personal email and I/we authorize Hospital or its agents to contact us via that e-mail address.

WORKER'S COMP / LIABILITY / AUTO ACCIDENT

If the reason for your visit is related to a workers comp claim, liability claim, or auto accident, you are responsible for providing Hospital with complete billing information, including police report, claim number, etc. as appropriate, within seven (7) business days. If you do not provide this information, or these claims are denied, the balances then become your/undersigned's responsibility.

INSURANCE AND ASSIGNMENT OF BENEFITS

If the patient has active insurance coverage, we will bill the patient's insurance company, and you understand that Hospital is authorized to submit treatment information and records as necessary to receive payment. I/we assign insurance payments to be made directly to Hospital for services rendered. It is the patient's responsibility to understand his/her insurance coverage. You will receive a monthly statement if the account has a balance due from patient. Payment of deductibles, non-covered services and co-payments are your responsibility.

PHYSICIAN FINANCIAL INTEREST DISCLOSURE

Hospital is a limited liability company organized under the laws of the State of Indiana. The hospital is privately owned, and a portion of our ownership includes a group of physicians. If you would like to receive a list of the physicians who are hospital owners, please ask your admitting representative. This disclosure is provided in accordance with Centers for Medicare and Medicaid Services.

NOTICE OF NONDISCRIMINATION

I have received a Notice of Nondiscrimination. I understand that The Women's Hospital complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

I/we have read, understand and agree to the terms listed above. This Financial Responsibility Form is good for one year from date of patient/guarantor signature.

Date: _____ Patient Signature: _____

Guarantor: (Minor's Parent, Guardian, Spouse or Representative)

Printed Name _____

Signature _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a Notice of Privacy Practices from The Women's Hospital.

Signature _____ ***Date*** _____

(Must be signed by): patient, guardian, power-of-attorney/health care representative, parent for minor

For Business Use Only:

A Notice of Privacy Practices was provided but no acknowledgment was obtained due to:

___ ***Patient Refused***
___ ***Patient Too Ill to Sign***
___ ***Patient Unlikely to Comprehend***
___ ***Patient Asleep/Unconscious***
___ ***Emergent Condition***
___ ***Other: (Explain)***

Registrar Name: _____ ***Date:*** _____