Financial Policy & Agreement

Patient Name: _____ **DOB:** _____/_____/_____

Our indigency discount is no different than all PPO discounts from BCBS or all other commercial insurers in compliance with all applicable federal and state laws with respect to indigency assistance without any routine waiver of cost sharing, advertising, or solicitation, for underinsured or uninsured patients. **Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount** without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the heal plan coverage, based on the provider's actual total and reasonable charges in accordance with Provider's Company Indigency Policy, as **the Indigency determination itself is a good effort to collect**, and hospitals or doctors are NOT required under any federal or state laws, Medicare, ERISA & PPACA, to take low-income, medically indigent, uninsured or underinsured patients to court, garnish their wages, or seize their homes, or send claims out to a collection agency when those patients don't or can't pay their hospital or doctor bill.

In consideration of my particular medical needs and care expenses to be incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional actual total charges regardless of any applicable insurance coverage. **I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:**

- ☐ Middle class income, with high deductible/ co-insurance, as medically indigent (see CMS definition below)
- ☐ Middle class income, Cash Pay–without any or applicable insurance for treatment from this provider/facility
- ☐ Low or a fixed income, with financial hardship, as financially indigent

Most importantly, I declare that without following indigent assistance, seeking for and continuing with medically appropriate and important health care would be impossible for me or would make me indigent if I were forced to pay full charges for my medically necessary care expenses. I also declare that I personally requested for such indigent assistance only after I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs and availability for this provider Indigency Policy. **Without my expressed permission, NONE of my private financial information or documents may be released to any 3rd party TPA, except for this Indigency Agreement of only medical information as requested by my health plan/ TPA.**

"Nothing in the Centers for Medicare & Medicaid Services' (CMS) regulations, Provider Reimbursement Manual, or Program Instructions prohibit a healthcare provider from waving collection of charges to any patients, Medicare or Non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the healthcare provider indigency policy."

*"By "**Indigency Policy**" we mean a policy developed and utilized by a healthcare provider to determine patient's financial ability to pay for services. By "**Medically indigent**," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses."*

I specifically request under this provider indigency policy for the following indigent discount assistance for the specific time periods from _____ to _____, after determining in good faith that I am in financial need or after reasonable collection efforts failed.

- ☐ Waiving collection of deductible _____
- ☐ Waiving collection of co-pays/encounter fees _____
- ☐ Waiving collection of co-insurance _____
- ☐ Waiving collection of total cost sharing _____
- ☐ I am only willing to pay monthly for a total of _____
- ☐ I can only afford to pay _____ for my total balance

Patient's Signature: _____ **Date** _____

Staff Signature: _____ **Date** _____