FHN Patient Financial Policy

Thank you for choosing FHN as your healthcare provider. We are committed to providing you with high quality and affordable health care. Please review our payment policy and sign below. A copy will be provided to you upon request and is available on our website, www.fhn.org

Forms of Payment Accepted: We welcome cash, check, electronic check, Visa, Mastercard, American Express, and Discover Card.

Referral or Pre-Authorization: If your insurance plan requires a referral authorization from your primary care provider (such as HMO plans) or a pre-authorization from your insurance, you will need to contact your primary care provider or insurance company to ensure it has been obtained. If we have yet to receive authorization prior to your appointment time, we will reschedule. Failure to obtain the referral or preauthorization may result in a lower payment or no payment from the insurance company and the balance will become the patient's responsibility.

Insurance: As a courtesy to our patients, it is our policy to bill your insurance. We must obtain a copy of your driver's license or valid identification card along with a copy of your current and valid insurance card. If you fail to provide your ID or insurance card, your balance will become patient responsibility. Please contact your insurance company with any questions you may have regarding your insurance as coverage varies.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Out of Network Insurance: If we are not in-network with your insurance plan, you will be responsible to pay 30% of estimated charges at the time of service and sign a Notice and Consent with Good Faith Estimate prior to services being provided. We will file your insurance claim as a courtesy to you and you may owe an additional payment depending on how your out of network insurance processes the claim.

Co-payments: All co-pays are due at the time of service. This arrangement is part of your contract with your insurance company. We are required by your insurance to collect your copay at the time of service.

Uninsured Patients: If you are not currently insured you will be required to make an initial payment at the time of service that will be pre-determined based on the service(s) being provided to you. Please note that not all healthcare services can be anticipated in advance such as labwork, EKGs, x-rays, etc. There could be an additional payment required if those services are needed.

Non-covered Services: Please be aware that services you receive may be deemed non-covered by your insurance. As a result, per your insurance, the charges may become patient responsibility.

Coverage Changes: If there are changes to your coverage, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum insurance benefits. It is your responsibility to notify us of changes in your coverage or the balance will be billed to you.

Nonpayment: If your accounts is over 90 days past due, you will be sent a final notice and will have 30 days to pay your balance in full or arrange a payment plan. Please be aware if your balance remains unpaid, we may refer you to a collection agency.

Financial Assistance: FHN provides financial assistance for medically necessary health care provided at FHN to patients who meet the financial and documentation criteria outlined in our FHN Discounts and Financial Assistance Programs Policy. A financial assistance application and screening tool can be found on our website at www.fhn.org.

Accounts in Bad Debt: If you have current accounts in a bad debt status you may be required to pre-pay for your services before receiving them.

NSF Fee: Checks or other forms of payment returned for insufficient funds will result in an additional fee.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

_____ _____

Signature of Witness **Date**