Chestnut Hill Hospital • 8835 Germantown Ave • Philadelphia, PA 19118-2718

NAME: **MRN:**

FINANCIAL RESPONSIBILITY

Thank you for choosing Chestnut Hill Hospital, (here in after referred to as "Facility") as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare.

We ask that you read and sign this form to acknowledge understanding of your patient financial responsibility.

In consideration of the services provided by Chestnut Hill Hospital (which includes Tower Health Medical Group):

- I assign to Facility all hospital and medical provider benefits that may be paid by: an insurance company, health plan, employer, governmental agency including but not limited to Medicare, Medicaid, or any other payer of such benefits (all may be known as the "Payer"); and related rights that exist under the Payer coverage that I have identified or will identify, for the services provided.
- I approve any such Payer to make payments directly to Facility. I also know that I am giving my approval for Tower Health Medical Group to give all related patient health information, including privileged information (for example: mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until stopped by me in writing.
- I understand that any payment received by Facility for this period may be applied to any unpaid bill(s) that I am responsible for.
- I understand that different Payers have different rules for payment including, but not limited to, pre-certifications, referrals, authorizations, or that the services be medically needed.
- I understand that it is my responsibility to know my Payer's rules and make sure that they have been met.
- I understand and agree that I need to pay for any charges not covered by this assignment and agree to pay Facility the full balance that is not paid by my hospital and medical provider benefits (certain rules and exceptions may apply for contracted Payers).
- If Facility decides to pursue an appeal of any denials by my Payer of the payment for services given, this financial responsibility statement serves as my written consent that Facility and/or its agents have the power to pursue any and all appeals, including arbitration, on my behalf. This financial responsibility is confirmed and accepted by my signature below.
- I understand that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the major credit bureaus, if not paid in a timely manner.
- I hereby grant permission and consent to Facility, its assignees and third party collection agents, to contact me by telephone at any telephone number associated with me, including wireless numbers provided by me, to leave answering machine and voicemail messages for me, to send me text messages or emails using any email addresses I provided, and to use prerecorded/artificial voice messages and/or an automatic telephone dialing system, in connection with any communications made to me, including billing, payment, debt collection, and any other communications required by law.
- I also agree that if I have provided a cell phone number(s) to Facility, that Facility or any of its agents may use that number(s) for contact purposes.
- I understand that I must pay all co-payments, deductibles, co-insurance, and any non-covered and/or out-of-network reduced benefits, at the time services are provided.
- A bill will also be sent to me, for any additional amounts, which are not paid by my Payer.
- It is my responsibility to make sure that payment and/or correct information for payment is given to Facility, for payment of services provided.
- I understand that if I have alleged that my treatment is related to a work injury or illness, that my information will be sent to the worker's compensation insurance carrier of my employer or its designated Third Party Administrator.

______________________________ ______________________________

Printed Name of Patient/Guarantor Date

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Signature of Patient/Guarantor

For questions or concerns, or for more information regarding financial assistance or payment plan options that may be available to you, please call our Financial Call Center: 484-628-5820 or toll-free 866-333-5820. Or email Call.Center@towerhealth.org.

A copy of this form is available upon request.