0956E

FINANCIAL AGREEMENT

1. FINANCIAL AGREEMENT

I agree to promptly pay all hospital bills in accordance with the regular rates and terms of LLUCH, including its charity care and discount payment policies, if applicable. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. All outstanding balances from any account must be satisfied prior to any refund from any account being issued. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

_____Patient/Legal Representive initials

2. ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to LLUCH of all insurance benefits payable for this emergency visit, any outpatient or inpatient services. I agree that the insurance company's payment to LLUCH pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I am financially responsible for the charges not paid according to this assignment.

3. HEALTH PLAN OBLIGATION

LLUCH maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. LLUCH has no contract, expressed or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by the hospital if I belong to a plan that does not appear on the contract list mentioned above. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if physicians providing services to me contract with my health plan, if any.

I agree to accept financial responsibility for services rendered to me and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits and Health Plan Obligation provisions above. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

4. TRANSFER TO CONTRACTED FACILITY

I acknowledge that I may be asked to transfer to my contracted facility for medical treatment once I am stable to do so. I have been informed that I will be financially responsible should I refuse to do so.

_____Patient/Legal Representive initials

Signature _____Date:_____Time:_____
Patient/Legal Representative

Relationship to Patient (if signed by Legal Representative): _____

Witness Name (print):_____

Witness Signature: _____Date:_____Time:_____

Interpreted by: ☐ Certified Interpreter ☐ Qualified Bilingual Staff ☐ Language Line
☐ Other (relationship):_____

Interpreter Name (print):_____

Interpreter Signature (if present):_____ Date:_____ Time:_____

Language Line Interpreter ID# (if applicable):_____Date:_____ Time:_____