PELOSI MEDICAL CENTER

PATIENT FINANCIAL AGREEMENT

Attachment 17.43(a)

I understand that, for services rendered by Dr. Pelosi II/III or the Staff of Pelosi Medical Center, my insurance carrier will be billed initially; however, I am responsible for the balance of the charges, or in the event that the insurance does not cover these charges, the total balance. If I am covered by an HMO or insurance plan in which Dr. Pelosi II/III is a participating provider, the insurance company's payment shall be regarded as payment in full, assuming all deductibles and co-payments have been met.

I understand that these charges are for services rendered by Dr. Pelosi II/III or his staff only and do not include the charges of other physicians, such as anesthesia, surgical assistants or consultants that may be necessary for my proper care. Nor does this include hospital charges. In addition, it is possible that at the time of surgery, additional procedures may be found necessary, and I may be charged for these services.

Additionally, I understand that many insurance companies require preauthorization and/or referrals for the hospital and that Dr. Pelosi II/III and their staff will fulfill their obligation to obtain these referrals and preauthorization. I may need to go to my primary care physician's office to pick up these referral forms and bring them to Pelosi Medical Center. I agree to cooperate in providing any necessary information and completing any forms which the insurance company requires for the successful processing of the insurance claim.

I understand that if I do not complete a necessary form or respond to an inquiry by the insurance company regarding the processing of this claim that such action may result in the non-payment of the claim by the insurance company. Under these circumstances responsibility for payment of this claim will be placed solely upon me.

I understand that if forwarding of this debt to a collection attorney becomes necessary for the collection of this debt, all reasonable legal and collection fees may be added to my bill and become my responsibility. This fee may be 35% or more of the outstanding medical bill. In addition, interest may begin to accrue on the outstanding bill.

Release of Information: **Init _____**

I hereby authorize the supplier to release any information required to process this claim.

Assignment of Benefits: **Init** _____

I acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only. I authorize payment directly to the provider.

PRINT NAME: _____

SIGNATURE: _____ DATE: ___/____/____