ACADIA	**Business Office**	**Policy# ALL,ACHC.BO,0160**
	ACHC.BO.0160 - Financial Assistance	**Effective: 06/01/2012**
		Last Reviewed/Revised: 10/30/2025
		Superseded Policy#

1. SCOPE

Acadia Healthcare Co., Inc., including all subsidiaries, affiliates, facilities, and their personnel.

2. PURPOSE

To determine qualifications for financial assistance.

3. POLICY

It is the company's policy to provide financial assistance based on federal poverty guidelines to patients with no health insurance or other state or federal health assistance or for whom the out of pocket expenses are significant. All financial assistance will be provided based on established protocols and completion of the Financial Disclosure Form (Attachment A) and supporting documentation.

4. PROCEDURE

All facilities must perform verification of benefits for each patient and each potential payer prior to or upon admission. If an admission occurs after normal business hours, the verification must be performed no later than the next business day. This Insurance verification process should be completed to identify any potential resources for the patient's medical services, whether federal or state governmental health care program (e.g. Medicare, Medicaid, state or local government agency, Champus, Medicare HMO, Medicare secondary payer), private insurance company, or other private, non-governmental third party payer source.

Financial assistance is not considered to be a substitute for personal responsibility. It is the responsibility of the patient/responsible party to actively participate in the financial assessment process

and provide timely, accurate information, as requested. This requested information may include information concerning actual or potentially available health benefits such as COBRA coverage or Medicaid/state or local government agency coverage. Failure to provide accurate and timely information may subject the patient/responsible party to a denial of financial assistance.

Self-pay/Uninsured Patients

All self-pay/uninsured patients (no current insurance coverage) will be requested to pre-pay for all services at time of admission/registration. Each facility must have a self-pay deposit schedule based on various estimated lengths of stay and the facility's established self-pay rate. This deposit schedule should be used to estimate the upfront payment that is required for self-pay patients.

If the patient is unable to pre-pay for services, the patient will be financially assessed during the pre-admission or admission process. The Financial Counselor, or designated Business Office staff member, will then meet with the patient and request that Attachment A - Financial Disclosure Form be completed. This form must be completed verbally or in person before the Equifax reporting tool can be utilized.

As stated in further detail in ACHC.BO.0150 Financial Counseling policy, the Financial Counselor or Business Office Representative will meet with each patient or guarantor expected to have an out-of-pocket responsibility to discuss payment arrangements and facilitate the completion of the Financial Disclosure Form.

Financially or Medically Indigent Patients

Financial assistance can be provided to qualified patients in accordance with the discount scale outlined in this policy. Financial Indigence can be determined by the verification of Medicaid eligibility for the dates of service. Financially and medically indigent patients are defined in further detail in the definitions found at the end of this policy.

If the patient is unable to pay estimated out-of-pocket expenses, the patient will be financially assessed during the pre-admission or admission process in accordance with ACHC.BO.0150 Financial Counseling policy. During the counseling session, the Patient Responsibility Worksheet will be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated cost-share.

During the financial counseling process, the facility may reasonably determine that COBRA coverage is available to the patient. In these cases, the patient will provide the facility with information necessary to determine the monthly COBRA premium by completing the Application for COBRA Assistance (Attachment D). If the facility determines that the patient is financially unable to pay the COBRA premiums the facility may decide to pay the COBRA premium on behalf of the patient/responsible party. Payment of any COBRA premiums must be approved by the facility CEO and CFO prior to payment.

Determining Qualification for Financial Assistance

The Patient Responsibility Worksheet along with the Financial Disclosure Form will be reviewed by the Business Office Director (BOD) and facility CFO. These completed forms are required for the qualification of patients for financial assistance.

The BOD or Financial Counselor is responsible for ensuring the completion of the Financial Disclosure Form by the patient/responsible party during the financial counseling process to evidence their ability to pay. All supporting documentation should be attached to the Financial Disclosure Form such as insurance verifications, proof of income and Equifax.

The BOD or Financial Counselor must verify the income of the patient/responsible party during the qualification process. The facility must have at least one form of documentation from the list below in order to verify and analyze the information received on the Financial Disclosure Form to determine financial assistance available for a patient/responsible party.

Documentation for income verification must be provided to the facility in order for the

patient/responsible party to be eligible for financial assistance. Eligibility for financial assistance may be determined at any time the facility is in receipt of documentation for income verification. To complete Income Verification, the facility will accept one of the following:

- Most Recent Income Tax Return (must document income for the year in which the patient/responsible party was first billed or 12 months prior to when the patient/responsible party was first billed)
- Most Recent Paystubs (must cover the 6-month period before or after the patient/responsible party was first billed, or for preservice, within 6-months of when application is submitted)
- Social Security Statement of Earnings
- SSI Disability Benefit Letter or Current Bank Statement showing Monthly Deposit
    - SSI Income via Direct Express is acceptable when a bank statement is unavailable.
- Unemployment Vouchers (must span 4 weeks or 30-day period)
- Letter from a Third Party Source such as a Shelter, Mission or Group Home confirming Financial Status

Equifax can be used to further analyze patient's financial status for medically indigent patients but cannot be the primary source of data in the qualification process. Income verification documentation is the primary method in which financial assistance will be determined.

Final approval of the financial assistance offered to the patient will be determined by the facility management, such as the Chief Financial Officer or Chief Executive Officer (CFO/CEO) based on their review of the completed Patient Responsibility Worksheet, the completed Financial Disclosure Form and documentation required for verifying income of the patient/responsible party. Facility management (CFO/CEO) will be responsible for reviewing eligibility disputes.

Approval and Recording of Financial Assistance

Financial or medical indigence (categorized as charity or indigent care on the facility's accounting

records) must be identified prior to the patient's discharge and must be logged on the Charity Log within the month identified. Once approved, Charity Adjustments will be written off by the facility in the patient accounting system no later than the end of the month following discharge with the exception of insured patients which can be adjusted at the time of the payment is posted or reconciled.

Facilities involved in a joint venture with a non-profit organization must be aware of the different guidelines for the time period in which a patient may qualify for charity care and follow the agreed upon policy.

Upon identifying a self-pay 100% charity patient at admission --enter the self-pay payer in the patient's account so that a self-pay discount will post. Indigent accounts pending Medicaid approval should not be immediately written off as Charity. Patients who are in process of being qualified for Medicaid eligibility should be included in the Medicaid Pending Financial Class and discounted at the Medicaid reimbursement rate. If it is determined after discharge that the patient is not eligible for Medicaid coverage, however the patient meets indigent criteria for the facility, move the account to financial class "SX" for self-pay charity and process the patient's account balance (gross charge less Medicaid contractual) for a charity adjustment. The expected payment for services provided to a patient/responsible party at or below 400% of the federal poverty level is limited to the amount of payment the facility would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

SAN JOSE BEHAVIORAL HEALTH DISCOUNT SCALE 2022

Income Level	% of Discount on Total Charges*
Equal to or less than 133% of FPG	100%
134%- 150% of FPG	75%

151% - 200% of FPG	50%
201% - 400% of FPG	25%
Greater than 400% of FPG	0%

* The expected payment for services provided to a patient/responsible party at or below 400% of the federal poverty level is limited to the amount of payment the facility would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

Payment Plans

Payment arrangements may include an extended payment plan. The facility may negotiate the terms of the payment plan with the patient/responsible party while taking into consideration the patient/responsible party's family income and essential living expenses. The facility may consider the patient/responsibly party's health savings account when establishing a payment plan. If the facility and patient/responsibly party cannot agree on the payment plan, the facility will create a reasonable payment plan, where monthly payments are not more than 10% of the patient/responsible party's monthly family income, excluding deductions for essential living expenses.

Definitions:

Equifax is one of the largest sources of consumer and commercial data in the world and has been providing business solutions using advanced analytics and the latest technologies for over 100 years.

Financial Assistance also known as Charity Care or Discount is defined as a reduction in the cost of health care services granted to patients based on their capacity to pay their estimated liability.

Financially Indigent is defined as those patients who are accepted for medical care who are uninsured

with no or a significantly limited ability to pay for the services rendered. These patients are also defined as economically disadvantaged and have incomes at or below the federal poverty guidelines. An individual may also be classified as "categorically needy" by proof of entitlement to some state or federal government programs such as SSI, Food Stamps, Aid to Families with Dependent Children (AFDC), or Medicaid for which entitlement has been established, but for which coverage may not be available for the specific type or level of service.

Medically Indigent is defined as those patients who incur severe or catastrophic medical expenses but are unable to pay and/or payment would require substantial liquidation of assets critical to living or would cause undue financial hardship to the family support system.

As noted in Accounting Policy # 115.00 Administrative, Denial, and Charity Care Adjustments, the following approvals are required for any Administrative or Charity Care patient account adjustment

- BOD/CFO approval is required for financial assistance up to $5,000.
- Additional approval by CEO is required for financial assistance greater than $5,000 with Divisional CFO approval being required above $10,000 as stated in Policy #115.00 Administrative, Denial, and Charity Care Adjustments.

A form letter provided, Notification of Determination of Eligibility for Financial Assistance (Attachment B) can be used as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

All documentation for financial assistance must be maintained in the patient financial file. The amount of financial assistance will only be applied after recovery from all third party payers has been verified, Reductions in revenue deemed financial assistance shall not result in a credit balance or a refund situation. Facility will reimburse the patient/responsibly party any amount over $5.00 actually paid in excess of the amount due including interest within 30 days.

How to Calculate the Amount of Financial Assistance (Discounts)

This method is intended to illustrate a sliding scale. It should be used as a guide for facilities in conjunction with the completion of the Financial Disclosure Form and determination of any financial assistance.

This method uses the Federal Poverty Guideline (FPG) Schedule. This schedule can be accessed from the internet by putting the following data in your web browser -

https://aspe.hhs.gov/poverty-guidelines. For San Jose Behavioral Health in the State of California scale is 100% discount up to 400% FPO subject to the limit on expected payment. First, find the number of the guarantor's dependents under the column labeled "Family Size". Then, locate the guarantor's gross annual income on the same row as the Family Size. In most cases, the guarantor's income will fall between two percentage categories (much like the tax schedule individuals use each year in determining how much they owe the government).

- With this information, determine the discount percentage based on the discount scale included herein. Example: Mr. Jones is uninsured and has met the criteria for the financially indigent. According to his federal income tax return, Mr. Jones earned $35,000 and has 4 dependents. Mr. Jones's total charges are $20,000. In this example, Mr. Jones's income level is 139% of the FPO and would therefore be eligible for a 50% discount of $10,000. Mr. Jones will be responsible for the remaining balance of $10,000. However, the expected payment from Mr. Jones will be limited to the amount of payment the facility would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

5. REFERENCES

Attachments:

Attachment A -Financial Disclosure Form

Attachment B - Notification of Approval/Denial for Financial Assistance

Attachment C - Charity Log

Attachment C - Charity Log

Attachment D - Application for COBRA assistance

Related Policies:

ACC-115.00	Administrative, Denial, and Charity Care Adjustments
ACHC.BO.0150	Financial Counseling
ACHC.BO.0140	Insurance Verification

APPROVAL: Signed by: Lyna Zhang 9618A29938C84B5... Date: 10/30/2025

Lyna Zhang
San Jose Behavioral Health CFO

Policy Title: Collections

Policy Number BO-111.00

Effective Date: July 1, 2012 **Revised Date**: October 30, 2025

Policy:

The facility's Business Office Director (BOD) is responsible for the collection of the patient accounts and identifying/resolving any obstacles in the collection process. Business Office staff shall actively pursue payment from third party payors on all outstanding account balances. Collection efforts will continue until an account balance is zero by means of payment or the appropriate adjustment. All collection activity pertaining to patients and third parties will be conducted timely as well as accurately documented in the patient accounting system. Pursuant to the policy, information obtained from income tax returns, paystubs, or the monetary asset documentation collected for the purposes of determining discount or charity care eligibility will not be used for collection activities.

Procedures:

Accounts are assigned to the Business Office staff alphabetically and/or by Financial Class (FC). All Biller/Collectors are cross trained as backup for all payors when needed. Each Biller/Collector

is required to work 35 to 45 accounts per day depending on the facility's payor mix and levels of care. All collection activity for all accounts should be clearly documented on the patient's account within the patient accounting system. This documentation should include, at a minimum, the following:

- ✓ Collector's name
- ✓ Date of Activity
- ✓ Name and phone number of person contacted
- ✓ Current status of the claim
- ✓ Summary of actions, discussions, resolutions, due dates, etc.
- ✓ Any check numbers and check dates, if applicable

Biller/Collectors should work all remittances and correspondence on a daily basis within 72 hours of receipt to ensure accounts are paid correctly. All contractual adjustments should be completed in accordance with policy **BO-109.00 Contractual and Patient Account Adjustments.** All Administrative, Charity and Denial Adjustments should be completed and processed by the BOD in accordance with policy **ACC-115.00 Administrative, Denial, and Charity Adjustments.**

All denials are to be accounted for by logging and tracking them in the patient accounting system. All denials should be handled in accordance with policy **BO-112.00 Denial Review.** Accounts in an appeal status shall have follow up no later than every twenty eight (28) days. Facilities may choose to use internal and/or external resources in appealing denials regardless of the level of appeal.

Policy Number: BO-111.00 Collections/AR Review

Patient complaints should be forwarded to the Business Office Director for review. BOD will review complaint with the facility CFO/CEO for the validity of any issue reported and work to

resolve immediately.

Returned refunds and mail items will be followed up on within 10 business days of receipt. When bankruptcy notifications are received, Biller/Collector will do the process in policy **BO-114.00 Notification of Bankruptcy.**

For all accounts due by third party payors, the Business Office must confirm that the payor received the claim within 14 days of submission for paper claims and 7 to 10 days for electronic submissions.

- Collection efforts for these billed claims should take place every 14 days or more often as circumstances or payor practices may require.
- Subsequent follow up will occur no later than every 14 days, on average, until the expected payment amount is received.
- These minimum standards should be guided by the facility's service levels and payor philosophy.
- A follow up tickler system should be used to track the date of the next scheduled follow up and to notify the collector of such date.

For all self-pay/private pay accounts, the Business Office will send monthly statements and utilize an early out preferred vendor. Accounts are placed and returned through an automated process which must be reconciled by the Business Office Director on a monthly basis. The placement process goes as follows:

- Self-Pay accounts (FC = S) are placed with vendor 5 days post discharge.
- Self -Pay after Insurance/Medicare (FC =SI and SM) are placed with vendor once the accounts have been placed in these financial classes.
    - S and SI changes to F4 - returns are placed into R4

    - SM changes to F7 - returns are placed into R7

- Financial Classes - SR, ST, SC and SX are not a part of the automated process.
- Accounts are returned from the early out vendor within 120 days.
- The accounts in R4/R7 will need to be reviewed for collection agency placement. Once the early out vendor's efforts are exhausted, the accounts will be placed with agency in accordance with policy **BO-113.00 Bad Debt Write Offs.**

AR Meeting/Review

In order to identify/resolve obstacles to the collections of patient accounts receivables (AR), it is recommended that the BOD/CFO have regularly scheduled AR meetings involving key departments such as Admissions and Utilization Management as well as the Biller/Collectors. **Attachment A - AR Meeting Minutes** provides a recommended guideline for the content of such a meeting. These meetings should be held weekly with the frequency being modified dependent upon the ability of the facility to meet their key metrics such as Cash Collections, AR Days and Bad Debt Expense.

The AR Review process should be a part of the standard Business Office practice. A Summary Aging report from the patient accounting system should be tracked monthly to identify unfavorable trends. System generated payor specific work lists should be used as an efficient tool to address multiple accounts with payors. High dollar accounts and accounts aged over 60 days should be given special priority and worked with greater urgency.

Each weekly AR Meeting should focus on accounts/payor issues affecting cash collections and bad debt expense. The BOD should "Know the Bad Debt Roll" which is defined by each facility's individual bad debt policy. A schedule of working aging buckets each week in addition to working current accounts will assist the BOD in knowing what issues are occurring in the patient accounts well before they become bad debt expense.

A recommended schedule for working aging buckets is as follows:

- Week 1/Month End-Accounts over 181 days old and Credit Balances
- Week 2 - Accounts 151-180 days old
- Week 3 - Accounts 121-150 days old
- Week 4 - Accounts 91-120 days old
- Start over with Week 1. If there is a Week 5 then it can be used to redouble your efforts on the significant known payor issues.

The patient accounting system and dashboard reports offer many ways to review the detail of the patient accounts as well as collector productivity. The key is to make use of all the available resources and be proactive in working patient accounts and the related payor issues.

Attachments:

Attachment A- AR Meeting Minutes

Related Policies:

ACC-115.00 Administrative, Denial, and Charity Adjustments

BO-109.0	Contractual and Patient Account Adjustments
BO-112.00	Denial Review
BO-113.00	Bad Debt Write Offs
BO-114.00	Notification of Bankruptcy

Approvals:

Administrative: Signed by: Debbie Kraemer 9A83A3C2A96D4BD... Date 11/2/2025 | 9:46:57 PM CST

SAN JOSE
BEHAVIORAL HEALTH

Help Paying Your Bills

It is the company's policy to provide financial assistance based on federal poverty guidelines to patients with no health insurance or other state or federal health assistance or for whom the out of pocket expenses are significant. Financial assistance can be provided to qualified patients in accordance with the discount scale outlined in our policy. If you need help paying your bill, there are organizations that will help patients understand the billing and payment process. Information regarding the Health Consumer Alliance can be found on its website at https://healthconsumer.org.

How to Apply

Information for the company's patient financial policies, procedures, and/or eligibility information can be obtained by contacting the hospital's Business Office at 669-234-5959 option 3. For a complete list of the facility's shoppable services, please visit 455 Silicon Valley Blvd., San Jose, CA 95138 or visit online at www.sanjosebh.com.

If the patient is unable to pay the estimated out-of-pocket expenses, the patient will be financially assessed during the pre-admission or admission process in accordance with ACHC.BO.0150 Financial Counseling policy. During the counseling session, the Patient Responsibility Worksheet (Attachment A -Policy ACHC.BO.0150 Financial Counseling) will be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated cost-sharing amount.

Determining Qualification for Financial Assistance

The Patient Responsibility Worksheet along with the Financial Disclosure Form will be reviewed by the Business Office Director (BOD) and facility CFO. These completed forms are required for the qualification of patients for financial assistance.

All supporting documentation should be attached to the Financial Disclosure Form such as insurance verifications, bank statements, proof of income and Equifax.

To complete Income Verification, the facility may accept one of the following:

- Most Recent Income Tax Return (must document income for the year in which the patient/responsible party was first billed or 12 months prior to when the patient/responsible party was first billed)
- Most Recent Paystubs (must cover the 6-month period before or after the patient/responsible party was first billed, or for preservice, within 6-months of when application is submitted)
- Social Security Statement of Earnings
- SSI Disability Benefit Letter or Current Bank Statement showing Monthly Deposit
- SSI Income via Direct Express is acceptable when a bank statement is unavailable.
- Unemployment Vouchers (must span 4 weeks or 30-day period)
- Letter from a Third Party Source such as a Shelter, Mission or Group Horne confirming Financial Status

Equifax can be used to further analyze patient's financial status for medically indigent patients but cannot be the primary source of data in the qualification process. Income verification documentation is the primary method in which financial assistance will be determined.

Final approval of the financial assistance offered to the patient will be determined by the facility management (CFO/CEO) based on their review of the completed Patient Responsibility

Worksheet, the completed Financial Disclosure Form and documentation required for verifying income and assets of the patient/responsible party.

How to Calculate the Amount of Financial Assistance (Discounts)

This method uses the Federal Poverty Guideline (FPG) Schedule as a guide for facilities in conjunction with the completion of the Financial Disclosure Form and determination of any financial assistance.

This method. This schedule can be accessed from the internet by putting the following data in your web browser – https://uspe.hhs.gov/poverty-guidelines. For Pacific Grove Hospital in the State of California, scale is 100% discount up to 400% FPG subject to the limit on expected payment. First, find the number of the guarantor's dependents under the column labeled "Family Size". Then, locate the guarantor's gross annual income on the same row as the Family Size. In most cases, the guarantor's income will fall between two percentage categories (much like the tax schedule individuals use each year in determining how much they owe the government).

Income Level	% of Discount on Total Charges*
Equal to or less than 133% of PG	100%
134%-150% of FPG	75%
151% - 200% of FPG	50%
201% - 400% of FPG	25%

Greater than 400% of FPG	0%

*****The expected payment for services provided to a patient/responsible party at or below 400% of the federal poverty level is limited to the amount of payment the facility would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

A Notification of Determination of Eligibility for Financial Assistance is provided as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

Hospital Bill Complaint	**More Help**	**How to access if you have disability or need in another language**
Contact HCAI Department of Health Care Access and Information Hospital Bill Complaint Program 2020 West El Camino Avenue, Suite 1101 Sacramento, CA 95833	Contact our Business Office Tel: 669-234-5959 Option #3 Fax: 669-234-5958	Contact our Business Office Tel: 669-234-5959 Option #3 Fax: 669-234-5958

Notification of Approval/Denial for Financial Assistance

_____

(Facility Name)

Date: _____

Guarantor Name: _____

Guarantor Address: _____

Guarantor City, State, Zip: _____

Patient Name: _____

Patient Account Number: _____

Date of Service: _____

Dear Mr/Mrs _____,

We have carefully reviewed your application for financial assistance and have determined that your account:

( ) meets the facility's established guidelines for financial assistance

( ) meets the facility's established guidelines for financial assistance pending outcome/resolution of your Medicaid application

Approved per diem or % of charges: $_____

Total approved discount amount: $_____

( ) does not meet the facility's established guidelines for financial assistance

Reason for denial:

____ monthly income exceeds qualifications

____ potential third party payor source through _____

____ application not complete

____ supporting documentation not adequate

If you have any questions, please call _____ at _____.

Sincerely,

Facility Business Office Representative

Attachment BO-104 Notification of Approval/Denial

SAN JOSE BEHAVIORAL HEALTH FINANCIAL DISCLOSURE FORM

Name of Patient/Guarantor Patient Account #

Social Security Number Date of Birth

Employer _____ Phone _____

Gross monthly income $_____

Any additional Source of income (child support/alimony) $_____

Total Monthly Gross Household Income (Proof of income required) $_____

Date last worked _____ Employment status _____ (FT, PT, Seasonal, Retired, unemployed)

Number of dependents including Self: _____ Marital Status _____

Housing: Own _____ Rent _____ Monthly payment $_____

Please list any other financial information to be considered in determining your ability for payment:

Cobra eligible? Yes or No If yes, insurance company _____ premium _____

To receive healthcare at a reduced cost to you, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this disclosure. For patients applying only for discount payment, only recent paystubs or income tax returns are required for documentation. Completion of the Financial Disclosure Form does not guarantee that you will be eligible for a cost reduction in your healthcare.

Patients that only apply for discount payment may receive less financial assistance than what may be available under the charity care program.

I authorize representatives of San Jose Behavioral Health and its affiliates to verify the information on this form and to release any of my information for payment purposes. The information given above is true and complete. I agree to notify San Jose Behavioral Health of any changes in my financial situation. I further authorize San Jose Behavioral Health and its affiliates to review and inquire into my credit history, including using a Credit Bureau History Report, Employer W2 verification, and/or IRS verification.

Signed _____ Date _____

Witness _____ Date _____

SAN JOSE BEHAVIORAL HEALTH

Patient Responsibility Worksheet

Patient/Guar. Name _____ Acct No. _____

Admission Date _____

Is the patient covered by any of the following?

Medicare _____ Lifetime psych days available _____

Medicaid _____

Other Govt. _____

Assistance _____

Health Ins. _____

Please provide copies of any online verification completed for any of the above items.

A. Charge Per day or Per Diem Rate:

B. Estimated Length of Stay: _____

C. Estimated Total Charge/Rate (Line A x B) $0.00

D. Patient Responsibility

1. Deductible	$0.00
2. Admit Fee	$0.00
3. Co-Pay per day/session	$0.00
4. Co-insurance %	$0.00

E. Estimated Patient Liability

1. Estimated Total Charge/Rate (Item C above)	$0.00
2. Less Deductible/Admit Fee (D1 + D2 above)	$0.00
3. Difference (E1 minus E2)	$0.00
4. Estimated co-pay (D3 times B above)	$0.00
5. Estimated co-insurance (E3 times D4))	$0.00
6. Estimated patient liability for this stay	$0.00
7. Out of pocket maximum	

F. Balances Due from previous stays

Acct #_____	Balance	$0.00
Acct #_____	Balance	$0.00

Total Estimated Patient Liability	**$0.00**

Has the patient been hospitalized in the past 90 days? _____

If Yes, when and where? _____

_____

The above estimate was calculated using the information that we received from your insurance company. Your signature below acknowledges that you have been informed of the estimated amount that is your responsibility.

_____ Date _____

Patient or Guarantor

Witness

(Administrative Use Only)
Approval Signature:_____ Date _____