CHESTNUT HEALTH SYSTEMS

FINANCIAL RESPONSIBILITY AND AUTHORIZATION

Patient Name	Patient ID#	Patient Birth Date

Name of Responsible Party	Relationship to Patient

The following outlines Chestnut Health Systems financial responsibility policy. This policy applies to all locations where services are provided. Staff will assist you in reviewing and explaining this form prior to your appointment. Please read each section and initial.

Payment Policy Initial: _____

If we are billing insurance or other payers on your behalf you will be responsible for any required copays, co-insurance and deductibles at the time of service. In the event you are self-paying for services, payment in full is expected at the time of service unless alternative arrangements are made with our business office.

Responsibility for Payment Initial: _____

Chestnut Health Systems participates with several major insurance companies as well as Federal, State and local payors. If you provide your current insurance card(s) and information at your visit we will bill your insurance company as a courtesy to you. We encourage every patient to understand their medical benefits. If you need further clarification, please contact your insurance company directly. Benefits quoted or services authorized by your insurance company do **not** guarantee payment for services. You will be responsible for any required co-pays, co-insurance, and deductibles identified by your insurance plan or other payers. Once your claim has been processed by your payer, any remaining balance will be billed to you.

If you have any financial obligation identified by your payer(s), you will receive an itemized statement identifying charges incurred and any payments received during the statement period and the amount due. Any balance due is payable in full **within 30 days** of receipt of such statement unless alternative payment arrangements are made with our business office.

Accounts not paid in full within **90** days are considered delinquent and may be assigned to a collection agency. If your account becomes delinquent and is referred to a collection agency, you will be responsible for any collection and/or legal fees assessed.

Release of Information Initial: _____

I authorize Chestnut to disclose to and/or obtain from my insurance company, Medicare/Medicaid, and/or any third-party payor or funding source any information needed to obtain authorization and payment for services rendered to me.

Assignment of Benefits Initial: _____

I authorize and direct that any insurance proceeds payable for services rendered by Chestnut to me be paid directly to Chestnut and I hereby assign to Chestnut all interest in, and rights to claim, collect and receive, the proceeds from any insurance company providing coverage for these services. Any payments received by Chestnut from me or my insurance company may be applied to offset any balances in my account.

Patient Name:	ID#:

CHESTNUT HEALTH SYSTEMS

Financial Assistance Determination (Illinois Only) Initial: _____ ☐ N/A

Chestnut receives state and local funding to assist with the costs of treatment for individuals who do not have the means to pay for the full cost of services. In order to receive financial assistance, I understand that I must complete the fields below and provide the required supporting documentation.

1. I ☐ am/ ☐ am not currently employed.
2. I ☐ do receive / ☐ do not receive unemployment benefits.
3. My current family/household income is $_____.
4. I have _____ dependents, including myself.
5. I ☐ am/ ☐ am not currently receiving medical assistance under the Medicare or Medicaid programs.
6. I understand that if I qualify to receive assistance, the fees for services rendered to me will be based on a sliding scale and I agree to pay the following copays indicated below:

Substance Use Program Per Service/Per Day	Mental Health Program Per Service/Per Day	Chestnut Family Health Center Per Service/Per Day
$ _____	$ / % _____ (Circle One)	$ _____

I confirm that I have been given copies of the following: Initial: _____

☐ Financial Responsibility Authorization Form (this document signed and dated)
☐ Chestnut Health Systems Fee Schedule
☐ Chestnut Health Systems Payment Policy

Signature

My signature below indicates that the information provided above is true. I understand that if any of the above information is false, I will not be eligible for financial assistance and will be required to pay the full Chestnut fees. I understand that I have the right to review and copy the information I am permitting to be released.

_____ _____
Printed Name of Responsible Party Date

_____ _____
Signature of Responsible Party Date

_____ _____
Signature of Witness Date

FOR STAFF USE ONLY

Proof of Income Documents Provided

☐ Paycheck/Unemployment Stub ☐ W-2 ☐ Proof Of Unemployment
☐ 1040 (Tax Return) ☐ Other:

Patient Name:	ID#: