



HENRY MEDICAL CENTER

CONSENT TO PAY FOR SERVICES RENDERED

The undersigned understands that the patient's insurance company or other third party payor may deny payment for part or all of the charges for hospital services rendered to the patient whose name appears below. Such denial may occur after the patient is discharged and may be on the grounds that such hospital services and supplies were deemed to be not medically necessary or were not covered services under the patients agreement with their insurance company, regardless of the fact that the patient's physician ordered the services and believed them to be medically necessary. The undersigned hereby agrees to reimburse the hospital directly for any and all hospital services and supplies determined by the patient's insurance company as not being medically necessary.

If the patient's insurance company has not paid within thirty (30) days from the date of billing, the patient is responsible. Balances owed after insurance payment are due and payable, in full, within thirty (30) days unless other arrangements have been made through the Patient Accounts Department.

Please note : Insurance is filed as a courtesy for our patient's benefit.
The Patient/Guarantor is still responsible for all charges and payments.

Patients without insurance are expected to pay in full at the time of discharge. Payment is required unless previous arrangements have been made through the Patient Accounts Department or the patient qualifies for the hospital's indigent care policy. All emergency room charges should be paid in full at the time of discharge. The patient/guarantor understands all amounts that may be quoted at the time of discharge are estimates and additional charges may be incurred during treatment or testing.

All insured patients must present current eligibility cards and will be asked to pay all deductibles or non-covered charges which may be due at time of discharge.

To assist our patients in paying for services rendered, various payment options are available: personal checks, money orders, travelers checks and major credit cards.

The undersigned has read and received a copy of this form and certifies that they are the patient, the patient's legal representative, or are duly authorized by the patient as the patient's general agent to execute this consent to pay for services and accepts its terms.

DATE: _____

TIME: _____

WITNESS: _____

PATIENT/PARENT/GUARDIAN/GUARANTOR

If signed by other than patient, please indicate relationship:

If signed by other than patient, please indicate reason:

If patient or patient's representative refused to sign, the notation "Patient Refuses to Sign" should be made in the space for the patient's signature and the Witness (the person who received the refusal to sign) should sign the form in the proper space.