THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160 **FINANCIAL POLICY**	**Do not write in this box** DT5149 AMB Financial Policy	**Name:** _____ **DOB:** _____ **MR#** _____

Thank you for selecting The University of Kansas Health System as the health care providers for you and your family. We want all of our patients to understand our financial policies regarding payments, insurance filing and collection.

Whenever you change address, telephone number, family status, insurance, etc., please call registration or inform us at check in.

We require a copy of your insurance cards. We need your insurance information for filing claims. If you cannot provide a current insurance card, you will be responsible for your fees at the time of service. We will also file an insurance claim if the insurance card is provided. After the insurance company has made payment, you will be refunded any monies due.

All co-pays, deductibles, authorizations, and/or referrals are due at the time of service. If you have an HMO insurance carrier, it is your responsibility to obtain an insurance referral authorization from your primary care physician. This referral should specify The University of Kansas Health System, The University of Kansas Hospital and/or The University of Kansas Physicians, name of the specific provider you will see, and the time range the referral will cover.

If either The University of Kansas Hospital or The University of Kansas Physicians does not have a contract with your insurance company, your visit may be considered out- of-network. This may increase your out-of-pocket cost or result in denied services. It is possible that you will be in network for The University of Kansas Hospital and not for your physician.

If you do not have health insurance, or you are out-of-network with your insurance, you will be responsible for paying for all services rendered. By signing this document, you agree to pay The University of Kansas Health System the amount billed for treatment at the time of the visit. If you have no insurance, you may be eligible for financial assistance.

Monthly statements will be mailed from The University of Kansas Health System. Please review your statements for accuracy and report any questions to our billing office. Accounts will be placed with a collection agency after 90 days of no activity. If you are on a payment plan and miss your monthly payment, the account may be turned over to collections.

Patients who fail to come for their appointments and do not notify the clinic in advance prevent other patients from being seen in a timely manner. Please provide at least 24-hours' notice in advance if you need to cancel or reschedule your appointments by calling your clinic directly or by calling the Health Resource Center at (913) 588-1227. Patients who repeatedly fail to attend or cancel their scheduled appointments may be subject to dismissal by either the individual department affected or by other departments within the Health System.

AUTHORIZATION TO BE CONTACTED: I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by The University of Kansas Health System or any entity to which The University of Kansas Health System assigns my account. I also consent to the use of any updated or additional contact information that I may provide by The University of Kansas Health System or any entity to which The University of Kansas Health System assigns my account. I consent to the use of technology, including an automatic telephone dialing system and/or artificial prerecorded voice message, in contacting me regarding any matter related to my account. I understand these calls are for debt collection purposes, and not advertisements or for telemarketing purposes. I understand that I can revoke this consent for automated calling at any time by contacting Customer Service for The University of Kansas Health System at 913 588-5820 (Toll free: 1-877-287-6268).

AUTHORIZATION FOR RELEASE OF BENEFIT INFORMATION
I authorize the release of any and all information requested by The University of Kansas Heath System in accordance with my applications for state benefits, federal benefits or other related benefits. My signature on this release is intended to provide for the free exchange of information between all such agencies and The University of Kansas Health System.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INSURANCE REPRESENTATION
I assign all rights to benefits, insurance proceeds or other payments or judgments that I may be entitled for hospital -based physician services, outpatient-based services, and office-based services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier. I authorize The University of Kansas Health System or an organization providing the services on its behalf to act as my representative to request reconsideration by my managed care plan or utilization review committee for coverage or grievance review.

Please sign back of form

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My signature below acknowledges that I have read and understand this document and am authorized to sign.

_____
Signature of Patient or Surrogate Decision-maker*

_____
Printed Name of Surrogate Decision-maker*

*Relationship to Patient: ____ Parent ____ Legal Guardian
____ Durable Power of Attorney (DPOA)
____ Spouse

_____
Today's Date

Interpreter Required: ___ YES ___ NO
If yes,
Mode of Interpretation:
___ Sight Translated ___ Interpreted

_____
Signature of Interpreter

_____
Interpreter's Printed Name

_____ _____
Today's Date Time

*Authorization must be signed by the patient, or if applicable, by an appropriate surrogate decision-maker.