Financial Obligation Statement

Thank you for choosing Liberty County Hospital and Nursing Home, Inc./Liberty Medical Center as your primary care provider. We are committed to providing you with quality and affordable health care. Please read this Financial Obligation Statement, ask us any questions you may have and sign in the space provided. A copy is being provided to you and additional copies will be provided to you upon your request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we do business, payments must be received in accordance with our payment policy. If you are insured by a plan with which we do business, but don't have an up-to-date insurance card, payment is required as stated in our collection policy until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments and deductibles**. All co-payments and deductibles are your responsibility. This arrangement is part of your contract with your insurance company. We are obligated to collect all co-payments and deductibles according to Federal Law.
3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full accordance with our collection policy.
4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency. Should the account be referred to a collection agency, you shall be responsible to pay reasonable attorney's fees and collection expense.
8. **Interest**. Interest, in the amount of 10% annually (0.83% monthly), will be charged to your account beginning with the first day of delinquency on your account according to our collection policy.

Our facility is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.