HELEN HAYES
HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

ADMFINOBL

Disclosure Statement and Acknowledgment of Financial Responsibility

Helen Hayes Hospital (HHH) will bill your insurance carrier(s) for services provided to you at our facility.

I, _____, understand that my insurance company
(*Name of Patient/Responsible Party*)
(except Medicare) may or may not participate with HHH. Further, I understand that although my insurance company (except Medicare), in general, may participate with HHH my particular policy may not be included in that participation status, may not include the benefit for the services provided, may have benefit limitations, or may require referrals/authorizations for certain services.

I acknowledge that I am ultimately responsible for knowing all of the information related to my benefits and how they apply at HHH and for providing the referrals/authorizations that are required.

I assign any insurance benefits to which I may be entitled from any insurance policy toward payment of my hospital bill; however, I understand that said payment may not constitute payment in full.

I understand and acknowledge that I am responsible for all charges and applicable surcharges for

services provided to _____that, for any reason, are not paid
(*Name of Patient*)
by my insurance company, and I agree that I am obligated to pay any known responsibility, including copayments, coinsurance, deductibles and applicable surcharges at the time of service and any other related balances, as stated above, within 30 days of receipt of statement from Helen Hayes Hospital.

_____ _____
Signature/Relationship to Patient Date

R526
05/20

_____
Address of Responsible Party

_____
HHH Employee Witness