

Miami Surgery, LLC.
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GENERAL STATEMENT OF PURPOSE:

This Financial Hardship Policy (“Policy”) is intended to establish criteria to determine the appropriateness of waiving or reducing self-pay fees, co-payments, co-insurance amount and/or deductible amounts for a prospective or current patient of Miami Surgry, LLC. (the “Practice”) and to assure that any such waiver or reduction of any payment that may be extended to such a patient by the Practice is authorized under the terms of this Policy.

POLICY:

The Practice will *not* permit any patient waiver or discount of self-pay fees, deductibles, co-insurance or other out-of-pocket amounts unless properly authorized under this Policy.

PROTOCOL:

Waiver Policy. It is the policy of this Practice to bill and collect the full amount of patient charges to a patient that seeks out-of-network services. Further, the Practice will bill and collect all applicable out-of-pocket amounts for patients seeking in-network services. The Practice will make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. However, if we determine that a patient’s financial situation meets the criteria for a reduction or waiver of out-of-pocket payment under the terms of this Policy, because such payment would pose a significant hardship to a patient to pay a out-of-pocket amount billed to the patient, the Practice may appropriately waive or lower such amounts.

Other Policies. Under no circumstances will the Practice engage in any of the following practices with respect to the waiver or lowering of self-pay fees, co-payments, co-insurance amounts and/or deductible amounts (“Required Patient Payment”) :

- Waive or lower a Required Patient Payment that does not meet the criteria outlined in this Policy.
- Advertise, or in any way communicate to the general public, that payments from private insurance, Medicare or Medicaid will be accepted as payment in full

for health care services provided by the Practice, or advertise or otherwise communicate to our patients or to the general public that patients will incur no out-of-pocket expenses.

- *Routinely* use financial hardship forms that state that the patient is unable to pay a Required Patient Payment, without obtaining requisite patient information and assurances.
- Charge Medicare beneficiaries or private insurance beneficiaries different amounts than those charged to other persons for similar services.
- Fail to collect Required Patient Payments from a specific group of patients for reasons unrelated to indigence, other financial hardship, or managed care contracting (for example, to obtain referrals or to induce patients to seek care in the Practice versus another provider's practice who does not waive co-pays and or deductibles).
- Accept "insurance only" or TWIP (take what insurance pays) as payment in full for services rendered.
- Fail to make a reasonable collection effort to collect a patient's balance due under a Required Patient Payment.

Determination of Financial Need

- Decisions to waive or reduce any Required Patient Payment owed by a patient will be made on a *case-by-case basis* only. To ensure that any decision to waive or reduce a Required Patient Payment is documented and based upon uniform objective criteria, *each patient who desires a waiver or reduction of a Required Patient Payment must complete, or assist one of our staff members in completing on his/her behalf, a Confidential Patient Financial Hardship Disclosure Application* (the "Application")¹. *A copy of the form, if completed over the telephone or otherwise outside of the presence of the patient, must be signed by the patient when he/she arrives at the office for consultation or services.* Copies of supporting documentation may be requested by the Practice either at the time of application or thereafter. The information in the Application will be compared to the Practice's policies to determine eligibility for waivers or lower payments. The Practice reserves the right to modify the criteria considered for a waiver or payment reduction without notice.

¹ See Attachment A

- Decisions to waive or lower a Required Patient Payment are based upon the financial and family information supplied by the patient in the Application and any supporting documentation, if requested by the Practice.

- *The Practice reserves the right to decline to grant waivers or payment reductions to patients without explanation.*

- The Practice reserves the right to seek full payment and collection costs and expenses from a Patient, notwithstanding the approval of such patient's Application, if any of the information in the Application is later found to be inaccurate or incomplete.

□ Criteria Considered in Determining Financial Hardship

- The Practice shall review the patient's Application and financial disclosure information *and* may take into account any extenuating circumstances applicable to the patient.

- One consideration that the Practice may take into account in determining whether and to what extent to waive or reduce a patient's Required Patient Payment is the following:

Is the Required Patient Payment with respect to the diagnostic or therapeutic procedure for which the patient is going to be seen expensive (creating a hardship for the patient) as compared with the patient's and the patient's immediate family's available income. Further, especially with regard to more expensive services, the Practice may consider the patient's family income as compared with 500% percent of the Federal Poverty Level. prone to find the Required Patient Payment difficult or impossible to meet:

SOURCE: *Federal Register*, Vol. 74, No. January 23, 2009, pp. 4199–4201

Those falling below the following criteria may be more

- The Practice may consider extenuating family circumstances such as (1) higher child care costs where there is either a single-patient household with children or both parents are employed and have expensive child care requirements, (2) a patient or his/her family has a bread winner who is either currently unemployed or under-employed, (3) where a family has experienced a significant illness, accidental injury or other unforeseen event that either significantly reduces family income or significantly raises family expenses, (4) the household is large with either numerous children or where grandparents or other relatives are living within the household or being substantially supported by the responsible family (usually where the family breadwinners can declare such individuals as dependents on their income tax returns), or (5) other demonstrable circumstances that substantially impact a patient's ability to partially or fully satisfy a Required Patient Payment.

- The Practice may ask the patient to provide supporting documentation, which may include one or more of the following: (i) most recent IRS tax forms (1040 tax return and W-2 withholding statements), (ii) paycheck stubs for the past 30 days for all persons employed in the home; (iii) unemployment

check stubs for past 30 days;; (iv) driver's license or identification card for adults; (v) proof of all other income received in past 30 days; (vi) proof of all outstanding bills (payment stubs, cancelled checks, etc.); (vii) forms or card from Medicaid or other state-funded medical assistance; (viii) forms from employers or welfare agencies; and/or (ix) evidence of other circumstances that indicate financial hardship, such as (A) proof of bankruptcy settlement, (B) catastrophic situations (death or disability in family, divorce, fire, flood or other natural disaster causing large damage to Patient or Patient's home, property or possessions), or (C) other documentation that shows that Patient would be unable to pay his or her medical bill and still be able to pay for other basic necessary expenses. The patient should be advised of this fact when information is collected for the Application.

Attachment A

Miami Surgery, LLC.

CONFIDENTIAL PATIENT FINANCIAL HARDSHIP DISCLOSURE APPLICATION

In order to be considered for a reduction or waiver of a patient's payment obligation under his/her insurance, the Practice's Financial Hardship and Waiver Policy requires that a Patient complete, to the best of her/his ability, by him/herself or with the assistance of our staff, this financial disclosure application and return it to the Practice for its review and determination. Any incomplete application may lack information that will assist the Practice in qualifying a patient for a payment accommodation.

Part I. Financial Disclosure Statement

1) Personal Information

Patient Name: _____

2) Place of Employment; Family Size and Employment

a. Patient employer (name and address): _____

b. Spouse's employer (name and address): _____

c. Number in Household: _____

d. Number in School and/or College: _____

3) Net Income – Monthly (please include salary, public assistance benefits, unemployment benefits, social security benefits, workman's compensation, disability, child support, alimony, pension and all other income)

a. Patient's income (or parent, if minor): _____

b. Spouse's income: (or second parent if minor): _____

4) Net Expenses - Monthly

a. Rent/House/Utilities Payments: _____

b. Car/Truck/Van - Financing and Insurance Payments: _____

c. Other monthly expenses (including food, credit cards, clothing, loans, medical/dental insurance, property and life insurance, child care, pet care, tuition, taxes, medical bills and expenses, etc.): _____

5) **Additional Circumstances:** Please describe other relevant circumstances (such as family member death or disability, divorce, extensive property damage, medical expenses, recent loss of employment, college tuition, etc.):

Part II. Acknowledgement; Supporting Documentation; Signature

The undersigned Patient hereby certifies and acknowledges that the information given herein is true and correct and that this application is made to allow the Practice to determine Patient’s eligibility for reduced out-of-pocket health care costs. Patient understands that the Practice is relying on the completeness and accuracy of the information provided by Patient and authorizes the Practice to verify any information contained in this document for the sole purpose of assessing financial need. All information relating to financial hardship requests will be kept confidential.

Upon request of the Practice, Patient agrees to promptly provide supporting documentation of financial hardship, such as tax returns, pay stubs, bills, cancelled checks etc.

If any of the information that Patient has given proves to be incomplete or untrue, the Practice will promptly reevaluate Patient’s financial status and take action necessary to collect on Patient’s account.

Signature of Patient

Today’s Date

(or parent/legal guardian if minor)

