ABBEVILLE AREA MEDICAL CENTER Smaller. Smarter. Safer.	Page 1 of 3
Subject: Financial Policy	Reference # PFS 0005
Department: Patient Financial Services	*"Say what you do, do what you say" - A.A.M.C.*

Purpose:

To ensure that Abbeville Area Medical Center has financial stability and can meet its mission and continue to provide medical services to the community and region, the following policies will be enforced:

To maintain a strong financial position, it is necessary to implement and adhere to established collection policies. The policies and procedures listed below enable AAMC to remain a viable health care provider.

Policy:

Non-Discrimination of Services:

Emergent medical services will be provided regardless of patient's ability to pay.

Payment Responsibility:

Abbeville Area Medical Center (AAMC) expects payment at time of service. Generally, AAMC will ask for unmet deductibles and estimated out-of-pocket co-payments amounts that the patient or patient's guarantor will owe. AAMC may also ask the patient to settle any outstanding accounts. AAMC's Patient Financial Services Department will bill adequate, verified, insurance plans for its patients if the patient provides the required insurance information and signs an assignment of benefits statement. The patient or legal representative is ultimately responsible for all charges incurred. All estimated deductibles and co-insurance amounts will be requested at time of service by means of cash, check, money order or credit card. Extended payment arrangements for patients requiring extra time to resolve self-pay portions must be established at time of service and meet established payment plans as set in the current policy.

Payment Agreements:

A payment plan will be offered to patients in cases where full payment is not possible. A financial counselor will review the account balance with the patient/guarantor and arrange to have the account paid in the shortest time possible, not to exceed 12 months. The Director, Business Office Services may extend payment terms up to 24 months. The CEO or CFO must approve payment terms beyond 24 months. Accounts with outstanding balances will be billed monthly. Accounts will be retained in AAMC when regular monthly payments are received on the account. Accounts become delinquent after the patient fails to submit payment within 15 days of the due date. Delinquent accounts will be placed with an outside collection agency.

Emergency Services:

Medical services will be provided regardless of the patient's ability to pay; however, AAMC shall pursue financial arrangements with the family or patient once the Emergency condition has passed and before the patient is discharged.

1) If condition is emergent, the patient will receive treatment regardless of his/her ability to pay.
2) If the condition is non-emergent, the patient will be required to pay a minimum of $100.00.
3) Patients with insurance will be expected to pay his/her co-pay and or deductible at the time of service.

Uninsured Patients/Non-Covered Services:
Payments for charges that are not covered by insurance are due and payable at time of service. Payments can be made by cash, personal check, money order, or credit card (VISA, MasterCard, or Discover). Patients unable to pay the deposit will be referred to a patient financial counselor who will assist the patient in making payment arrangements. Services - except those deemed emergent by the attending physician - may be delayed pending the financial counselor's review.

Emergent services are those that must be performed immediately in order to prevent undue suffering and/or potential loss of life or limb(s).

Preadmission Program:
- Preadmission information may be requested prior to scheduled admissions and outpatient service.
- Patients may be requested or required to make payment of the anticipated charges for elective, uninsured services *prior* to the date services are to be rendered.

Unpaid Insurance Balances:
Patients may be requested to make full payment of unpaid balances when the insurance payments are not received within 60 days from date of billing.

Elective Treatment:
Patients requiring elective or non-emergent services may be rescheduled if one or more of the following occurs:

1) Required deposit not made.
2) Acceptable payment arrangements not on file.
3) Previous delinquency without good cause.

Partial Insurance Coverage:
Patients with insurance policies that cover only a portion of the hospitalization must pay the difference between the charges and the insurance payment amount. This includes deductibles, co-payments, and non-covered services. This payment is due at time of service. A pre-admission deposit may be required. when insurance payments are not received after 60 days from date of billing.

Third Party Litigation:
AAMC will not become involved in disputes arising from third-party claims (automobile accidents, liability claims, etc.) with the exception of verified workers' compensation claims, or claims involving Medicare or Medicaid. Patients involved in such cases remain responsible for payment of all charges and will be subject to normal collection activities including referral to outside collection agencies and the South Carolina Tax Debt Set-off Program.

Prior Unpaid Balances:
Prior to the provision of outpatient services or scheduling a new admission, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements be approved by a financial counselor.

Referral to Outside Collection:
Accounts that fail to respond within 30 days of initial billing or fail to follow their established payment plan will be referred for outside collection.

Medical Debt Relief:
If a patient is found to be financially indigent, the financial counselors will assist the patient in applying for other financial assistance. If no source of financial assistance is available, the account will be considered for a charity allowance. In order to qualify for charity, the patient/guarantor must cooperate in applying for financial assistance.

Refunds:
Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $25.00 will not be issued to the insurance company and refunds of less than $10.00 will not be issued to the patient/guarantor unless specifically requested.

Discounts:
Insured Patients:
If you have insurance such as Medicare, Medicaid, Blue Cross, United Healthcare or other insurance plan where AAMC is a participant, your bill has already been discounted. Rates have been pre-negotiated with the insurer so the discount has already benefited the patient in the form of lower insurances rates than would have otherwise been required.

Uninsured Patients:
The following guidelines should be used to select the appropriate discount amount for our Private Pay patients:

1. 40% discount, if paid in full, on the day of service(s)
2. 30% discount, if paid in full, within five (5) of the discharge date
3. 20% discount, if paid in full, within 30 days of the discharge date
4. 10% discount, if paid in full, within 45 days of the discharge date