Exhibit 1

EAGLEVILLE HOSPITAL
FINANCIAL ARRANGEMENT PAYMENT AGREEMENT

Patient Name: ____

The patient or responsible party has reviewed the Payment Plan Financial Arrangement with an Eagleville Hospital Representative and understands and agrees to the outlined processes applicable to his/her plan or plans:

PAYMENT PLANS

- ☐ 1. I have **Blue Cross** and will pay any difference of charges not covered by my certificate as billed. I assign my insurance benefit payment and request payment be made directly to Eagleville Hospital.
- ☐ 2. I have **Commercial Insurance** and hereby **assign my benefits to Eagleville Hospital**. I will pay all charges not covered by my insurance as billed. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Eagleville Hospital of the hospital expense benefits (otherwise payable to me). I understand that I am financially responsible to Eagleville Hospital for the charges not paid by my insurance plan.
- ☐ 3. **Medical Assistance:** I am aware that there is a MEDICAL ASSISTANCE CO-PAYMENT of $____$6.00/____ $3.00 per day for the first seven (7) days of hospital stay. Payment of your co-pay is to be made at time of admission. Any unpaid portion must be satisfied prior to discharge by either check or withdraw of monies deposited in the Patient Fund Cashier Window. Any exception must be arranged through the Finance Department.
- ☐ 4. **Medicare:** I am aware that the services I receive may not be covered by my Medicare plan. In this event I understand I will be responsible for all charges not covered. I have received **"AN IMPORTANT MESSAGE FROM MEDICARE"** and I understand my rights as outlined in this document. I will be responsible for any Medicare deductible or co-insurance days and, if needed, I authorize the use of my Medicare Lifetime Reserve Days.
- ☐ 5. **Managed Care: (HMO's; Medicare Advantage; MA Programs)**: I am aware that I will be responsible for charges resulting from carrier deductibles, co-payments, and/or unauthorized services.
- ☐ 6. I will consult with the Finance Department to **make alternative arrangements for payment** of hospital charges.

In consideration of the above, Eagleville Hospital agrees to admit and/or retain client as a private patient. The undersigned party hereby assumes full responsibility for and agrees to pay all cost, charges, and expenses of Eagleville Hospital, every kind and description of service, facilities, food, medication, laboratory studies, and any other service or item supplied or furnished the patient. This is an (original) undertaking on the part of the undersigned, and the mobilizations of the undersigned to Eagleville Hospital. No extensions, indulgences, or forbearances which may be granted to the patient and on delay or lack of diligence of Eagleville Hospital in enforcing any rights against the patient shall in any manner release the undersigned or affect the undersigned's liability hereunder. If the undersigned is more than one (1) person, every obligation hereunder shall be joint and several. The obligations of the undersigned shall be cumulative with and in addition to all other remedies of Eagleville Hospital against the patient. Eagleville Hospital reserves the right to pursue collection of outstanding debt by their agents following no less than ninety (90) days of inactivity by the client to entirely satisfy the remaining balance, or make cyclical payments on account at no more than twenty-eight (28) day intervals. **In the event** the Department of Public Welfare rejects the Medical Assistance claim or the private and/or government insurance reject the claim submitted by Eagleville Hospital for payment of the cost of my care and directs the Hospital to pursue other private and/or government insurance, I understand and hereby authorize Eagleville Hospital to submit the claim**. In addition,** I authorize Eagleville Hospital to disclose to that private and/or government insurance only the information from the medical record that is reasonably necessary to effectuate the purpose, which is payment of the cost of my care.* If medical services not available at Eagleville Hospital are required during my hospitalization, I authorize the release of my healthcare coverage information and my address for the purpose of enabling the medical service provider to bill for rendered services. **ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT:** I hereby assign all my rights to benefits due or payable to me or on my behalf, and hereby authorize payment directly to Eagleville Hospital of all benefits payable to or on behalf of the above patient, not to exceed the hospital's regular charges for this hospitalization and/or rehabilitative episode of care and/or the charges of the physician or allied health professional. I agree, intending to be legally bound hereby, to be financially responsible for and to pay at the time of discharge all charges not covered by this assignment of insurance benefits and all charges if the insurance carrier does not make payment in accordance with this assignment. **THIS FORM HAS BEEN** FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS**. *Even with a patient consent,** disclosure to judges, probation or parole officers, insurance companies, health or hospital plans and government officials is limited to whether the patient is or is not in treatment, the patient's prognosis, the nature of the project, a brief description of the patient's progress, a short statement as to whether the patient has relapsed into drug or alcohol abuse and the frequency of such relapse.

(PATIENT SIGNATURE (DATE)	**(WITNESS SIGNATURE) (DATE)**

Copies of Agreement have been offered to patient:__Accepted__Rejected
Hospital Fee Schedule:___ Accepted___ Rejected

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(FAMILY MEMBER/SIGNIFICANT OTHER) (DATE)

Approved Medical Record Committee: 9/3/85 Revision Approved MRC: 1/21/16

EAGLEVILLE HOSPITAL

MEDICAL ASSISTANCE CORRESPONDENCE
INFORMED CONSENT

I, ____________________________________, give my consent to the PATIENT ACCOUNTS DEPARTMENT staff to open MEDICAL ASSISTANCE CORRESPONDENCE pertaining to my MA card.

I understand this practice is utilized in order to obtain accurate information for billing purposes and to facilitate reimbursement of hospitalization.

I further understand that the PATIENT ACCOUNTS DEPARTMENT staff will place a sticker on the envelope with staff's initials indicating the mail had been opened and by whom.

I have been informed that I have the right to revoke this consent at any time by oral or written request to FINANCIAL COUNSELOR, PATIENT ACCOUNTS DEPARTMENT except to the extent that the information has already been processed in accordance with the authorization.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

____ ____
PATIENT SIGNATURE **WITNESS SIGNATURE**

____ ____
DATE OF SIGNATURE **DATE OF SIGNATURE**

A copy of this consent has been offered to the patient

_____ **Accepted**

_____ **Rejected**

Approved Medical Record Committee: 9/3/85
Revision Approved MRC: 3/28/12

PtAccts-Financial Agreement