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Owner	Amanda Escobedo: Training Coord-Revenue Cycle
Policy Area	Patient Financial Services/Patient Access Services
Applicability	SCOR SCV SGH SMB SMC SMH SMV
References	Accounts Receivable, Person-Centered-Care, Planetree + 1 more

Billing, Collections and Bad Debt Review, 15801

I. PURPOSE:

To provide clear directives for Sharp HealthCare hospital facilities to conduct billing and collections functions in a manner that complies with applicable laws. Establish the guidelines for collection of monies owed for visits and the identification of bad debt visit referral.

II. POLICY

It is the policy of Sharp HealthCare to bill patients and applicable third-party payers accurately, timely and consistent with applicable laws and regulations, including, without limitation, California Health and Safety Code section 127400 et seq. and regulations issued by the United States Department of the Treasury under section 501(r) of the Internal Revenue Code.

III. SCOPE

This policy applies to all Sharp HealthCare Hospitals and Hospital Services. This policy also applies to

any collection agency working on behalf of a Hospital. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in a Hospital's bill. This policy does not create an obligation for the Hospital to pay for such physicians' or other medical providers services.

IV. DEFINITIONS:

A. **FINANCIAL ASSISTANCE POLICY:** The Financial Assistance Policy for Uninsured or Low Income Patients #15602.99 ("Financial Assistance Policy") is the Sharp HealthCare Policy on Financial Assistance (Charity Care). This describes Sharp HealthCare's Financial Assistance program – including the criteria patients must meet in order to be eligible for financial assistance as well as the process by which patients may apply for Financial Assistance (Charity Care).

B. **FINANCIAL ASSISTANCE:** "Financial Assistance" refers to Full Charity Care and High Medical Cost Charity Care, as those terms are defined in the Financial Assistance Policy.

C. **CHARITY CARE:** “Charity care” is free care.

D. **DISCOUNTED PAYMENT or DISCOUNT PAYMENT:** A “Discounted” or “Discount Payment” is any charge for care that is reduced but not free.

E. **OUT-OF-POCKET COSTS AND EXPENSES:** For purposes of determining whether a patient has “high medical costs,” “out-of-pocket” costs and expenses means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

F. **HOSPITAL OR SHARP HEALTHCARE HOSPITALS:** "Hospital" or "Sharp HealthCare Hospitals" means (a) all licensed hospital facilities operated by Sharp HealthCare and (b) all hospitals in which Sharp HealthCare and/or an Affiliated Entity has a direct or indirect voting control or equity interest of greater than fifty percent (50%) and all substantially-related entities (as such term is defined at 26 C.F.R. section 1.501(r)-1(b)(28)), to the extent such hospitals and substantially-related entities described in this clause (b) provide emergency services.

G. **HOSPITAL SERVICES:** "Hospital Services" are all services that a Hospital is licensed to provide, including emergency and other medically necessary care. re all services that a Hospital is licensed to provide, including emergency and other medically necessary care.

H. **GUARANTOR:** The party (person or company) with financial responsibility for the visit. For an adult visit, this is usually the patient.

I. **PATIENT FAMILY:**

- For patients 18 years of age and older, the definition of “patient’s family” includes dependent children of any age if those children are disabled.
- For patients (1) under 18 years of age or (2) who are 18 to 20 years of age and are a dependent child, the definition of “patient’s family” includes other dependent children of the patient’s parents or caretaker relatives if those other children are disabled.

J. **BILLED CHARGES:** "Billed Charges" are the undiscounted amounts that a Hospital customarily bills for items and services.

K. **PATIENT RESPONSIBILITY:** "Patient Responsibility" is the amount that an Insured Patient is responsible to pay out-of-pocket after the patient's third-party coverage from all third-party sources of payment has determined the amount of patient benefits.

L. **THIRD-PARTY PAYER:** Means anon-government third party payer that providers coverage for healthcare services to a Patient.

M. **COLLECTION AGENCY:** A "Collection Agency" is any entity engaged by a Hospital to pursue or collect payment from patients upon assignment.

N. **UNINSURED PATIENT:** An "Uninsured Patient" is a patient who has no third-party source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third-party liability, and includes a patient whose benefits under all potential sources of payment have been exhausted prior to an admission.

O. **SELF-PAY PATIENT:** An insured patient who will not submit a claim to their insurance for covered and/or non-covered services:

    1. Uninsured (or self-pay) individual means:

        a. An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal healthcare program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code; or

        b. An individual who has benefits for such item or service under a group health plan, or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code but who does not seek to have a claim for such item or service submitted to such plan or coverage. These services would not be eligible for submission to the payer by the patient to seek reimbursement.

P. **INSURED PATIENT:** An "Insured Patient" is a patient who has a third-party source of payment for a portion of their medical expenses.

Q. **EXTRAORDINARY COLLECTION ACTION:** Except as otherwise set forth below, an Extraordinary Collection Action (ECA) is any of the following:

    1. Selling an individual's Hospital debt to a third party, including, without limitation, to a Collection Agency.

    2. Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the Hospital's Financial Assistance Policy (which is considered an ECA to obtain payment for the previously provided care, not the care being potentially deferred or denied). If a Hospital requires a payment before providing medically necessary care to an individual with one or more outstanding bills for previously provided care, such a requirement for payment will be presumed to be because of the individual's nonpayment of such bill(s), unless the Hospital can demonstrate that it required the payment from the individual based on factors other

than, and without regard to, the individual's nonpayment of past bills.

3. Actions that require a legal or judicial process, including but not limited to:
    a. Placing a lien on an individual's property (other than a lien described below);
    b. Obtaining an order for examination.
    c. Attaching or seizing an individual's bank account or any other personal property;
    d. Commencing a civil action against an individual;
    e. Causing an individual's arrest;
    f. Causing an individual to be subject to a writ of body attachment; and
    g. Garnishing an individual's wages.

Extraordinary Collection Actions do not include the assertion of or collection under, a lien asserted under Civil section 3040 or 3045. Further, filing a claim in a bankruptcy proceeding is not an Extraordinary Collection Action.

1. ***Extraordinary Collection Action does not include:***
    a. Hospital's sale of an individual's debt for care provided by the Hospital if, prior to the sale, the Hospital has entered into a legally binding written agreement with the purchaser of the debt pursuant to which: The purchaser is prohibited from engaging in any ECAs to obtain payment for the care;
        i. The purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);
        ii. The debt is returnable to or recallable by the Hospital upon a determination by the Hospital or the purchaser that the individual is eligible for Hospital's Financial Assistance Policy; and
        iii. The debt is returnable to or recallable by the Hospital upon a determination by the Hospital or the purchaser that the individual is eligible for Hospital's Financial Assistance Policy; and
        iv. If the individual is determined to be eligible for Hospital's Financial Assistance Policy and the debt is not returned to or recalled by the Hospital, the purchaser is required to adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the Hospital together more than he or she is personally responsible for paying as a Financial Assistance-eligible individual.

b. Any lien that the Hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Hospital provided care, including the assertion of or collection under a lien asserted under Civil Code sections 3040 or 3045.

c. The filing of a claim in any bankruptcy proceeding. Proof of claims in any patient's Bankruptcy is not an ECA.

R. **STATEMENT LEVELS:** Means the number of statements sent to a patient. The first patient statement is mailed once the visit is final billed and patient responsibility is determined; subsequent statements are mailed approximately every 28 days for a total of 112 days. Standard billing provides the patient with four (4) statements. Once a payment plan has been established for reoccurring payment by credit card, statements are no longer sent. The Good Bye Letter will be mailed to any guarantor owing hospital charges after the expiration of the level four statement and 10-day prior to assignment of bad debt.

S. **CONTACT:** Direct connect or automated dialing system outbound calling to patients in attempt to offer payment arrangements, assistance with securing government source of funds or offering financial assistance. Hospital shall strictly adhere to applicable provisions of the Rosenthal Act, Fair Debt Collection Practices Act (FDCPA), Health Insurance Portability and Accountability Act (HIPAA), and Telephone Communication Practices Act (TCA).

T. **BAD DEBT:** The amounts due and owing to a Hospital for all goods and Hospital Services rendered to a patient by a Hospital where:

1. The guarantor/patient has the financial capability to pay for the goods or Hospital Services and (a) indicates that he or she does not intend to pay or (b) fails to come to an acceptable payment agreement; or
2. Hospital is unable to contact the guarantor/patient due to a lack of information on the visit, mail return, or no reply from contact attempts. Amounts due and owing from patients/guarantors with no information or mail return may be considered bad debt at any time. Amounts due and owing from patients/guarantors from whom no reply is received by Hospital may proceed through standard dunning cycles and will be considered for placement of bad debt or moved directly to dunning level 5.

Bad debts are transferred off the Sharp HealthCare Accounts Receivable balance and are assigned to a collection agency for further follow-up. The collection agency is not to enforce any ECA's or report any "derogatory/adverse action" to one or more credit bureaus on a patient until the greater of the following has been met: (a) 180-days after the Hospital provides the first post-discharge billing statement or (b) 180-days post- assignment to collection agency prior to credit reporting.

U. **PATIENT PROVIDER DISPUTE RESOLUTION:** A Patient-Provider Dispute Resolution (PPDR) process is available for uninsured (or self-pay) consumers who get a bill from a provider that is at least $400 more than the expected charges on their good faith estimate. Under the PPDR process, an uninsured (or self-pay) consumer, or their authorized representative, may initiate the dispute process. This process brings in an independent third-party called a dispute resolution entity to determine the appropriate amount the consumer must pay.

V. **MEDICAL DEBT:** "Medical debt" means a debt owed by a consumer to a person whose primary business is providing "medical services, products, or devices," or to that person's agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid.

- "Medical service, product, or device" does not include cosmetic surgery, but does include, without limitation, all of the following:
  - Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or providers.
  - Initial or subsequent reconstructive surgeries, and follow-up care deemed necessary by the attending physician and surgeon.
  - Initial or subsequent prosthetic devices, and follow-up care deemed necessary by the attending physician and surgeon.
  - A mastectomy.

V. PROCEDURES:

There will be reasonable attempt(s) to contact the patient/guarantor for debt resolution. Bad debt shall be transferred to a collection agency for collection only after several attempts to contact the patient/guarantor via statement or phone have been put forth or no contact information is available, or an agreement has not been established. The primary purpose of a collection contact is to advise the patient/guarantor of the outstanding debt and to obtain payment. Once a bad debt visit is identified, the visit will be reviewed prior to collection agency transfer to be sure reasonable resolution of outstanding issues and to identify government or Financial Assistance eligibility.

A. **Billing Third-Party Payers**

1. **Obtaining Coverage Information**: Hospitals shall make reasonable efforts to obtain information from patients about whether private or public health insurance or sponsorship may fully or partially cover the services rendered by the Hospital to the patient.
2. **Billing Third-Party Payers**: Hospitals shall diligently pursue all amounts due from third-party payers, including but not limited to contracted and non-contracted payers, indemnity payers, liability and auto insurers, and government program payers that may be financially responsible for a patient's care. Sharp HealthCare will bill all applicable third-party payers based on information provided by or verified by the patient or their representative in a timely manner.

B. **Billing Patients**: Sharp Hospitals shall grant to Sharp HealthCare the authority to pursue collections from patients on behalf and for the benefit of the Hospitals. To the extent Sharp HealthCare pursues collections from patients on behalf of the Hospitals; Sharp HealthCare shall comply with this policy.

1. **Billing Insured Patients**: Hospitals shall bill insured patient or secondary insurance for the patient responsibility amount as computed by the Explanation of Benefits (EOB).
2. **Billing Uninsured Patients**: Hospitals shall promptly bill Uninsured Patients for items

and services provided by Hospital, using Hospital's Billed Charges less the Standard Uninsured Discount.

a. For scheduled services, payment is due prior to the delivery of said services.

    i. Good Faith Estimates for anticipated services are available and delivered within 3 business days from scheduling when the service is scheduled more than 10 days in advance.

        a. For services scheduled within 3 days from the date of service the good faith estimate will be delivered within one business day.

    ii. In the event the final balance exceeds the good faith estimate the patient has the right to submit a patient

b. Standard Uninsured Discount: 25% reduction of Billed Charges for Inpatient Services and Outpatient Services.
*******The* **Uninsured Patient Discount does not apply to patients who receive services that are already discounted (i.e. package discounts or cosmetic services). Case rate and package rate pricing should not result in an expected payment that is less than what the Hospital would expect had the Uninsured Patient Discount been applied to Billed Charges for the services.**

3. **Financial Assistance Information**: All bills to patients shall include the Notice of Rights (back page of billing statement Attachment A to this Policy), which includes a summary of Financial Assistance that is available to eligible patients. Each Hospital shall make reasonable efforts to determine whether a patient is eligible for Financial Assistance under its Financial Assistance Policy. With respect to any care provided by a Hospital to an individual, the Hospital will have made reasonable efforts to determine whether the individual is eligible under its Financial Assistance Policy if it:

    a. determines the individual is eligible based on information other than that provided by the individual or based on a prior eligibility determination and, if the individual is presumptively determined to be eligible for less than the most generous assistance available under the Financial Assistance Policy, the Hospital:

        i. notifies the individual regarding the basis for the presumptive Financial Assistance Policy-eligibility determination and the way to apply for more generous assistance available under the Financial Assistance Policy;

        ii. gives the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and

        iii. if the individual submits a complete Financial Assistance application seeking more generous assistance during the application period, determines whether the individual is eligible for a more generous discount and satisfies the requirements of

the Hospital's Financial Assistance Policy and Section 3(B)(iii), below, with respect to the complete Financial Assistance application; or

iv. notifies the individual about the Financial Assistance Policy before initiating any ECAs to obtain payment for the care and refrains from initiating such ECAs (with the exception of an ECA described in Section 3 of the definition of ECA) for at least 112 days from the date the Hospital provides the first post-discharge billing statement for the care;

v. In the case of an individual who submits an incomplete Financial Assistance application during the application period, notifies the individual about how to complete the Financial Assistance application and gives the individual a reasonable opportunity to do so by suspending any ECAs to obtain payment for the care and providing the individual with a written notice that describes the additional information and/or documentation required under the Financial Assistance Policy or Financial Assistance application that must be submitted to complete the Financial Assistance application and that includes the telephone number and physical location of the Hospital office or department that can provide information about the Financial Assistance Policy; and

vi. In the case of an individual who submits a complete Financial Assistance application during the application period, determines whether the individual is eligible for Financial Assistance for the care and (A) suspends any ECAs to obtain payment for the care; (B) makes a determination as to whether the individual is eligible under the Financial Assistance Policy for the care and notifies the individual in writing of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination; (C) if the Hospital determines the individual is eligible under the Financial Assistance Policy for the care, does the following: (1) If the individual is determined to be eligible for assistance other than free care, provides the individual with a billing statement that indicates the amount the individual owes for the care as a Financial Assistance-eligible individual and how that amount was determined and that states, or describes how the individual can get information regarding, the amounts generally billed (AGB) for the care; (2) Refunds to the individual any amount he or she has paid for the care (whether to the Hospital or any other party to whom the Hospital has referred or sold the individual's debt for the care) that exceeds the amount the individual is determined to be personally responsible for paying as a Financial Assistance-eligible individual, unless such excess amount is less than Five Dollars ($5) (or such other amount as

may be set by notice or other guidance published in the Internal Revenue Bulletin); (3) Takes all reasonably available measures to reverse any ECA (with the exception of a sale of debt and an ECA described in Section 3 of the definition of ECA) taken against the individual to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the individual, lift any levy or lien (other than a lien described in the exceptions to ECAs in this policy) on the individual's property, and remove from the individual's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

4. **Detail Bill**: All patients may request an itemized statement (IZ) for their account at any time, excluding pricing for Flat Rate or Package Pricing.
5. **Disputes:** Any patient may dispute an item or charge on his or her bill. Patients may initiate a dispute in writing or over the phone with a customer service agent . If a patient requests documentation regarding the bill, staff members will use reasonable efforts to provide the requested documentation within 10-days. Hospitals will contest account and hold from
    a. Self-Pay/Cash Pay patient disputes
        i. Sharp will hold/pull back from collections
        ii. Discontinue any collection activity pending dispute
        iii. Review the timeliness requirements from PPDR.

C. **Good Faith Estimates (GFE):**

1. Notice of Right to Request GFE. Uninsured and Self-Pay Patients must be advised both orally and in writing that they have the right to request a GFE before they schedule an item or service, and if not requested, a GFE of expected charges must be provided upon scheduling.
2. Content of the GFE. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an Uninsured or Self-Pay Patient's actual Billed Charges.
3. Delivery of GFE. Pursuant to the Uninsured or Self-Pay Patient's requested method of delivery, the GFE must be provided either on paper or electronically (for example, electronic transmission of the GFE through provider's patient portal or electronic mail). If provided electronically it must be provided in a manner that allows the GFE to be saved and printed.
4. Timing of Delivery of GFE
    a. If an Uninsured or Self-Pay Patient requests the GFE prior to scheduling a service, the GFE must be provided no later than three (3) business days after the request.
    b. If a service is scheduled at least three (3) days, but less than ten (10) days in advance, the GFE must be provided no later than one (1) business day

after the date of scheduling.

c. If a service is scheduled at least ten (10) days in advance, the GFE must be provided no later than three (3) business days after the date of scheduling.

D. **Uninsured/Self-Pay Dispute Resolution Process:**

1. An Uninsured or Self-Pay Patient has the right to initiate the patient-provider dispute resolution process if the actual Billed Charges are at least $400 more than the total amount of expected charges listed in the GFE.
2. Within one hundred twenty (120) calendar days of receiving the initial bill containing charges at least $400 more than the GFE, an Uninsured or Self Pay Patient may initiate the patient-provider dispute resolution process by submitting a notification on the Federal IDR portal or on paper to the Secretary of HHS (U.S. Department of Health and Human Services).

E. **Collection Practices:** General Collection Practices: Subject to this policy, Hospitals may employ reasonable collection efforts to obtain payment from patients.

1. General collection activities may include issuing patient statements, phone calls, automated phone calls as per the Hospital's conditions of admission and referral of statements have been sent to the patient or guarantor.
2. No collection activities will take place during Financial Assistance Application Process: Hospital and Collection Agencies shall not pursue collection from a patient who has submitted an application for Financial Assistance and shall not engage in ECAs against a patient or guarantor to obtain payment for care before the Hospital has made reasonable efforts to determine whether the patient is eligible for assistance under the Hospital's Financial Assistance Policy.
3. Prohibition on use of Information from Financial Assistance Application: Hospitals and Collection Agencies may not use in collection activities any information obtained from a patient during the application process for Financial Assistance. Nothing in this section prohibits the use of information obtained by Hospital or Collection Agency independently of the eligibility process for Financial Assistance.
4. Payment Plans:
    a. Hospitals and any Collection Agency acting on their behalf shall offer patients who qualify for Financial Assistance the option to enter into an agreement to pay their patient responsibility and any other amounts due over time. Hospitals may enter into payment plans with patients who indicate they are unable to pay a Patient Responsibility amount in a single installment.
    b. Terms of Payment Plans: All payment plans made directly with the Hospital shall be interest-free. Patients shall have the opportunity to negotiate the terms of the payment plan. If a Hospital and patient are unable to agree on the terms of the payment plan, the Hospital shall extend a payment plan option under which the patient may make a minimum monthly payment of at least (a) an amount not to exceed ten percent (10%) of the patient's monthly family income after excluding essential living expenses or (b) $10 per month, whichever is greater,

though the patient may voluntarily pay more than these amounts. "Essential living expenses" means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and automobile, including insurance, gas, and repairs. Accounts subject to a payment plan shall not be subject to ECAs provided the patient remains in compliance with the terms of the payment plan.

c. Declaring Payment Plan Inoperative: An extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 30–61-day period. Prior to the extended payment plan being declared inoperative, the Hospital or Collection Agency shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.

5. Collection Agencies: Hospitals may opt to refer patient accounts to a Collection Agency, subject to the following conditions:
    a. The Collection Agency must have a written agreement with the Hospital.
    b. Hospital's written agreement with the Collection Agency must provide that the Collection Agency's performance of its functions shall adhere to Sharp HealthCare's mission, vision, core values, the terms of the Financial Assistance Policy 15602.99, this Billing, Collections and Bad Debt Review Policy 15801, and the Hospital Fair Pricing Act, as well as Health and Safety Code sections 127400 through 127446.
    c. The Collection Agency must agree that it will not engage in any Extraordinary Collection Actions to collect a patient debt.
    d. Hospital must maintain ownership of the debt (i.e. the debt is not "sold" to the Collection Agency).
    e. The Collection Agency must have processes in place to identify patients who may qualify for Financial Assistance, communicate the availability and details of the Financial Assistance Policy to these patients, and refer patients who are seeking Financial Assistance back to the Hospital's Patient Financial Services Department, 858-499-2400, or to www.Sharp.com/patient/billing/Financial-Assistance.cfm. The Collection Agency shall not seek any payment from a patient who has submitted an application for Financial Assistance and shall suspend ECAs to obtain payment until Financial Assistance Policy eligibility is resolved. If it is determined the individual is eligible for Financial Assistance, the Collection Agency shall (i) adhere to procedures specified in the written agreement with the Hospital that ensure the individual does not pay, and has no obligation to pay, the Collection Agency and the Hospital together more than he or she is required to pay for the care as a Financial Assistance-eligible individual; (ii) if applicable, and if the Collection Agency has the

authority to do so, take all reasonably available measures to reverse any ECA (other than the sale of a debt or an ECA described in Section 3 of the definition of ECA) taken against the individual; and (iii) if the Collection Agency refers or sells the debt to another party during the application period, the Collection Agency must obtain a written agreement from that other party including all of the elements described in this section.

f. All third-party payers must have been properly billed. A Collection Agency when notified, shall not bill a patient for any amount that a third-party payer is obligated to pay.

g. The Collection Agency, when notified, must send every patient a copy of the Notice of Rights, Attachment A. A Copy of the Good Bye Letter, Attachment B, when hospital charges present.

F. **Third Party Liability**. Nothing in this policy precludes Hospital affiliates or outside collection agencies from pursuing third party liability in a manner consistent with the Third-Party Lien Billing Practices.

G. For any contract creating a medical debt, a holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

VI. ATTACHMENTS:

A. Patient Informational Notice

VII. REFERENCES:

A. FDCPA
B. HIPAA
C. TCPA
D. Internal Revenue Code Section 501 (r)
E. 26 Code of Federal Regulations 1.501 (r) – 1 through 1.50 (r)
F. California Health and Safety Code section 124700 through 127446
G. No Surprises Act
H. AB-532
I. AB-2297
J. SB-1061

VIII. ORIGINATOR:

Patient Financial Services

IX. LEGAL REFERENCES:

None

X. CROSS REFERENCES:

A. FDCPA

B. Policy # 01951.99, Health Information: Access, Use & Disclosure

C. Policy # 15602.99, Financial Assistance for Uninsured or Low Income Patients

XI. APPROVAL:

A. PFS Policy and Procedure Committee – 04/96; 12/01; 12/04; 12/06; 12/09; 08/10; 08/13; 03/15; 03/16; 09/16; 08/19; 06/24; 12/24

B. System Policy & Procedure Steering Committee – 05/96

C. System Planetree Committee – 07/24

XII. HISTORY:

System #15801; originally dtd 5/96
Revised/Reviewed: 12/01; 12/04; 12/06; 12/09; 08/10; 08/13; 03/15; 03/16; 09/16; 06/2024; 12/2024

A. Attachment - Patient Informational Notice

Billing, Credit and Financial Assistance

Sharp HealthCare requests all patients to inform us of any health insurance coverage, including any county, state or federal programs. Sharp HealthCare cannot accept responsibility for the collection of insurance claims or for negotiating settlement on disputed claims. Although there may be an insurance claim pending, the patient remains responsible for payment to Sharp HealthCare. All fees are due upon rendering of services. Visits will be delinquent after 30 days of non-payment, unless alternative arrangements have been established with our business office. Continued delinquent visit(s) may be referred to a collection agency. For information regarding payment options, programs, or to request a free financial assistance application visit us at www.Sharp.com/billing/financial-assistance.cfm

If you have health insurance Coverage, Medicare, Healthy Families Program, Medi-Cal or other coverage or if you need information about payment options or financial assistance please contact us at (858) 499-2400. If you are uninsured or have high medical costs, please contact our Customer Service Department at (858) 499-2400 for information on discounts and programs for which you may be eligible, including the Medi-Cal program. You may be eligible for health coverage programs including Medi-Cal, and the California Children's Services programs, The California Health Benefit Exchange or other state or county funded health coverage programs. For local services in your area you may contact the Consumer Center for Health Education and Advocacy (CCHEA) by phone at (877) 734-3258 or online at www.healthconsumer.org

Third Party Liability

Sharp may also pursue payment from a third party if permitted by California Law. If we do, discounts may no longer be applicable. We expect you to pay when allowed by California and other law and equity.

Fair Debt & Consumer Counseling

State and federal laws require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (877-382-4357) or online at http://www.ftc.gov/. Please note that non-profit credit counseling services may be available in your area.

Attachments

A: Patient Informational Notice

Approval Signatures

Step Description	Approver	Date
Administrator	Tamara Westgate: Prgm Mgr-Policies and Procedures	12/26/2024
	Amanda Escobedo: Training Coord-Revenue Cycle	12/23/2024

Applicability

Chula Vista, Coronado, Grossmont, Mary Birch, McDonald Center, Memorial, Mesa Vista, Sharp HealthCare

References

Accounts Receivable, Person-Centered-Care, Planetree, Policy