



Financial Agreement of Commercial Insurance/HMO for Admission

All pertinent commercial insurance or HMO information with contact names and phone numbers are to be indicated in Part B on the standard LHH Referral Form.

Patient/Resident Name _____

1. I authorize and agree to cooperate in the direct payment to Laguna Honda Hospital (LHH) of any insurance benefits available to me or on my behalf for this hospitalization.
2. I understand and agree to the extent necessary to determine liability for payment and to obtain reimbursement, LHH may disclose portions of my record, including medical records, to any person or corporation which is or may be liable for all or any portion of the hospital's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers.
3. I understand and agree that if/when any commercial insurance benefits expire or coverage for LHH services is exhausted, I will cooperate in applying for Medi-Cal benefits and other government subsidies that may be available including Medicare.
4. I understand that I am financially responsible for any hospital charges not covered by my insurance assignment and/or Medi-Cal if pending certification. Financial responsibility shall be binding on me and my heirs, legal representative, executors and assigns.
5. I understand that if I am transferred to an acute hospital for care or take a leave of absence by pass order from my physician, LHH will hold my bed upon my request. I further understand that a charge of \$299 per day will be billed to my account for as many as my bed is held. If this is not a covered benefit with my insurance, I have the option of self-paying for the bed hold days.
6. I acknowledge that any overdue unpaid debts are subject to further collection process through Bureau of Delinquent Revenue for City & County of San Francisco.
7. I understand and agree that failure to comply with this agreement will result in termination of plans for admission, and if already admitted, will result in discharge from LHH.

I agree to the above stated conditions by my signature:

Date _____ Signature _____

Patient/resident or guardian or spouse or conservator
or power-of-attorney or other legal representative

Name of Guarantor _____

Phone # _____

LHH Representative _____