Banner Health®

FINANCIAL AGREEMENT

I agree that in return for the services provided to the patient by the hospital or other health care providers at the hospital or providers affiliated with Banner Health, I will pay the account of the patient and/or make financial arrangements satisfactory to the hospital and/or any other providers for payment. I agree, in order for you, your agents, or assigns to service my account or to collect any amounts I may owe, you may contact me by email or telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include text messages, using pre-recorded/artificial voice messages and/or use of any type of automatic telephone dialing system. This express authorization applies to any landline, cellular phone number, or email I may acquire in the future. I also agree to advise you if I discontinue, transfer or otherwise change the telephone number(s) I have provided to you within five days of such change. I also agree to such contact as necessary by any employees, agents, assigns, or third parties who work on behalf of physicians or other providers in my medical care. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for health services rendered to the patient. I understand and agree that a delinquent account will be subject to interest at the legal rate.

Estimated charges may be given at or before the time of service, but I understand that this is merely an estimate, based upon information that is available at the time and that the actual amount that the patient will be charged for medical services rendered may be different from the estimate of charges for a variety of reasons, including but not limited to, additional procedures, tests or supplies that were not covered in the estimate.

I understand and agree that my insurance and/or the patient's insurance, if any, will be billed for medical services rendered to the patient, and payment from the insurer will be sought by the hospital before I am required to make payment (with the exception of applicable co-payments, deductibles, and co-insurance until the out-of-pocket has been met, which I must pay). I understand and agree that I am responsible for and I will pay for medical services rendered to the patient in the event that our insurance does not authorize these services or does not pay for these services. I further understand and agree that as part of the normal business communication with Banner Health with regard to this matter, Banner Health staff or representatives may contact me through any of the following methods: letter, e-mail, telephone, text or voice messages, or any other available technologies used by businesses for such communications. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future.

If the patient or I am entitled to benefits of any type whatsoever, under any policy of health or liability insurance, or from any other party liable to the patient, that benefit is hereby assigned to the hospital and/or to the providers rendering services, for application toward the patient's bill. **It is understood and agreed, however, that the patient and I are primarily responsible for payment of the patient's bill and that we are obligated to pay and agree to pay for any portion of the bill that is not paid for by insurance or other sources.** If I am an employee of Banner Health, I authorize Banner to deduct from my paycheck past-due amounts that I owe to Banner providers for health care services provided to me or my dependents enrolled in the Banner Health Medical Plan. I understand that I may revoke this authorization at any time by notifying Employeeinquiries@bannerhealth.com.

In the event that the patient and/or I have made a payment on an active account, whether through cash, check, credit card or other means, and there remain additional funds available after that account is satisfied (e.g. an overpayment), Banner Health is authorized to apply the overpayment to any other account owed by the patient that remains unpaid.

Patient/Authorized Representative	Relationship
Witness ID Number	Date/Time
2nd Witness Signature (if needed)	