Patient Financial Services
2500 W Utopia Rd #100
Phoenix, AZ 85027
Phone: 623-300-9044
Fax: 623-464-6216
email: patientfinancial@honorhealth.com

BASIC FINANCIAL ASSISTANCE UNINSURED ATTESTATION

Effective January 1, 2020, HonorHealth Hospitals offers an eighty-four percent (84%) discount from billed charges for services provided to uninsured patients with household income less than five times the Federal Poverty Guidelines as outlined in the Financial Assistance policy. This policy may be viewed in the Financial and Privacy Policies section on HonorHealth.com. This discount may not be applicable to care received related to an injury where another individual or entity is responsible for payment.

Payment Expectations: The hospital expects a deposit prior to scheduled services and the balance or payment arrangements to be paid according to HonorHealth policy. Approximately one week after discharge, you will receive an itemized statement indicating the discounted balance due with contact information should you need to make payment arrangements.

In the event that another person or entity is responsible for the injuries giving rise to this treatment, the hospital retains its lien rights pursuant to A.R.S. 33-931, and will enforce its lien against any such recovery.

If the guarantor is unable to pay the hospital bill, or cannot make formal payment arrangements, notify hospital personnel immediately in order to initiate time-sensitive applications for other state, federal, or hospital programs.

These programs are subject to change or cancellation at any time.

ATTESTATION

I attest as the patient or guarantor of this account, that:

- The patient has no insurance for this service.
- The patient has no inpatient or outpatient insurance coverage at any hospital or healthcare facility that would cover these services.
- Household annual gross income is less than the amount listed below for my family size.

I understand this information may be verified through credit reporting services.

Family size	<500% FPL
1	$64,400
2	$87,100
3	$109,800
4	$132,500

Signature/Print Name _____ Patient Account # _____

Relationship to Patient _____ Date _____

PLEASE RETURN THIS FORM TO THE ADDRESS AT THE TOP OF THIS PAGE