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POLICY

This policy applies to the Johns Hopkins Health System (JHHS) Patient Financial Services (PFS) Division.

PURPOSE

To establish consistent telephone messages for dealing with a variety of collection scenarios (simple collection, contract payments, assignment of funds, offering financial assistance, etc.).

PROCEDURE

Collections staff will follow the appropriate script:

PFS Message left by Collectors

Hello, my name is (collector's name). ***I am calling from*** (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital) ***Collections Department for*** (name of patient/guarantor/responsible party) ***in reference to account #*** _____. ***Please return my call at*** (collector's phone number) ***between the hours of 8:30 AM and 5:00 PM—Eastern Time. Thank you.***

PFS Collections when the Party Answers (Payment in Full)

Hello, my name is _____ ***and my calls are recorded.* I am calling from*** (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital). ***May I speak with*** (name of patient/guarantor/responsible party)?

(When patient/guarantor gets on the phone:) ***Hello, Mr./Mrs./Ms.*** _____ ***; my name is*** _____ ***and I am calling from*** (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital) ***Collections Department. All of our calls are recorded.****


We have an account balance of \$ _____ ***from*** (date(s) of service _____) ***when you*** (or name of patient) ***were*** ((name of patient] was) ***seen at our facility. Do you have any insurance for this visit?***

(If patient/guarantor answers no:) ***How would you like to resolve this balance today—by check or by credit card?***

Establishing Contract Payment Agreement (Payment in Full Cannot Be Obtained)

Hello, my name is _____ ***and my calls are recorded.* I am calling from*** (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital). ***May I speak with*** (name of patient/guarantor/responsible party)?

(When patient/guarantor gets on the phone:) ***Hello, Mr./Mrs./Ms.*** _____ ***; my name is*** _____ ***and I am calling from*** (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital) ***Collections Department. All of our calls are recorded.****

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We have an account balance of \$ _____ from date(s) of service _____ when you (or name of patient) were ([name of patient] was) seen at our facility. Do you have any insurance for this visit?

(If patient/guarantor answers no:) **How would you like to resolve this balance today—by check or by credit card?**

(Patient/guarantor says he/she has no money to pay this balance:) **I understand. We can set you up on a monthly payment plan beginning (date and amount of initial payment); subsequent payments would be due in the amount of \$ _____ (negotiate up to limit on matrix—exceptions by Supervisor approval only) on the same day every month until the balance is paid in full.**

Broken Contract Payment Agreement

Hello, my name is _____ and my calls are recorded.* I am calling from (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital). May I speak with (name of patient/guarantor/responsible party)?

(When patient/guarantor gets on the phone:) **Hello, Mr./Mrs./Ms. _____; my name is _____ and I am calling from (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital) Collections Department. All of our calls are recorded.***

We have not received your monthly payment. Has your payment been mailed? If your payments are not made every month your account is subject to collection by an outside agency.


Offering Financial Assistance Application

(Remember to state that: **All of our calls are recorded.*** After establishing that patient/guarantor is unable to make payment on account:)

Mr./Mrs./Ms. _____, I will send you a Financial Assistance application today. When you receive this application, please complete it and mail it back to us with all the required information within 20 days. We will then determine if you are eligible to receive any financial assistance from this facility; within 48 hours of receiving your application, we will mail you a letter of determination.

Deceased Patient (not deceased at our facility)

(Remember to state that: **All of our calls are recorded.*** After expressing sympathy for the family member's loss:) **Would you please, at your earliest convenience, send a copy of the death certificate to my attention at Suite 300, 5300 Alpha Commons, Baltimore, Maryland 21224? Thank you.**

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Assignment of Funds

(After notification that an Attorney is representing patient:)

Hello, my name is _____ and my calls are recorded.* I am calling from (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital). May I speak with (name of attorney)?

(When attorney gets on the phone:) **Hello, Mr./Mrs./Ms. _____; my name is _____ and I am calling from (The Johns Hopkins Hospital/Johns Hopkins Bayview Medical Center/Howard County General Hospital) Collections Department. All of our calls are recorded.***

I understand that you are representing (name of patient). I would like to mail you an Assignment of Funds; can I please verify your address? Please sign the original and return it to me in the self-addressed envelope. Thank you.

Pay Online Options

(Remember to state that: **All of our calls are recorded.***)

We offer pay online for your convenience—either by credit card or e-check. Would you like to make payment today in full?

(After information is obtained:) **Would you like me to e-mail you a copy of your receipt? I will need your e-mail address; if you do not have an e-mail address I can mail your receipt directly to you today.**


If you would prefer, you may go online now and view and pay your own account at (Howard County General Hospital: www.hcgh.org); Johns Hopkins Bayview Medical Center: www.hopkinsbayview.org); or Johns Hopkins Hospital: www.hopkinshospital.org). You may then print out your receipt for your records.

***Note:** In the event that any person refuses to speak with a collector over a recorded telephone line, offer the following options:

(Email) **I understand. If you would prefer to communicate by Email, my address is (collector's Email address). May I please have your Email address? ... Thank you.**

(Regular Mail) **I understand. If you would prefer to communicate by mail, please write to my attention (repeat collector's name) at Suite 300, 5300 Alpha Commons, Baltimore, Maryland 21224. May I confirm your current mailing address? (repeat patient's address of record). Thank you.**

(Fax) **I understand. If you would prefer to send information by fax, please send it to my attention (repeat collector's name) at the following fax number: (fax number). Do you have a fax number we may use to reach you? ... Thank you.**

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SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL



 Senior Director, JHHS

2/16/09

 Date



 Director, PFS Operations, JHHS

1/23/09

 Date