



# Patient Financial Communications Best Practices®

# Patient Financial Communications Best Practices Steering Committee

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Executive Vice President and Chief Financial Officer, Intermountain Healthcare

The following national policymakers advised the project: Sen. Tom Daschle (D-S.D.), Sen. Bill Frist (R-Tenn.), former U.S. Secretary of Health and Human Services Donna Shalala, Gov. Michael Leavitt (R-Utah), and former U.S. Deputy Attorney General Jamie Gorelick.

# Foreword

Thank you for your interest in HFMA's Patient Financial Communications Best Practices®. At HFMA, we believe that ensuring a good financial experience for patients is important for many reasons—it reduces administrative costs and improves financial results for healthcare organizations, it enhances patient satisfaction and loyalty, and—perhaps most importantly—it helps patients make better decisions about their healthcare.

That's why we worked with leading organizations from all sectors of the industry to develop these best practices. HFMA then went on to create a recognition program based on the Best Practices. Some of the leading healthcare provider organizations in the country have sought and achieved Adopter recognition. To view a current list, visit [hfma.org/adopterorganizations](https://hfma.org/adopterorganizations).

In the process of applying for Adopter recognition, you will perform a self-assessment that can yield valuable information about where your organization's financial communications processes could benefit from improvement. Or you may receive validation that your financial communications processes are already aligned with industry consensus best practices. By *receiving* Adopter recognition, you will demonstrate your commitment to excellence in financial communications to your patients as well as to your employees, physicians, and community. In doing so, you not only strengthen your organization's reputation, you also help maintain consumer trust in healthcare overall. We look forward to welcoming you to the Best Practices Adopter community.

# Patient Financial Communications Best Practices®

These common-sense best practices bring consistency, clarity, and transparency to patient financial communications, and outline steps to help patients understand the cost of services they receive, their insurance coverage, and their individual responsibility. The best practices are organized into five sections:

1) Emergency Department, (2) Time of Service (Outside the Emergency Department), (3) Advance of Service, (4) All Settings, and (5) Measurement Criteria. The best practices are listed on the following pages.



## SECTION 1. BEST PRACTICES FOR THE EMERGENCY DEPARTMENT

All practices must comply with the Emergency Medical Treatment and Labor Act (EMTALA) and all other federal, state, and local regulations affecting the Emergency Department.

**1.1. DISCUSSION PARTICIPANTS.** The patient or guarantor will have these discussions with a properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine/complex scenarios. Patients should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.

**1.2. SETTING FOR DISCUSSIONS.** No patient financial discussions will occur before the patient is screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, the following timings and locations are appropriate for financial discussions.

**1.2.1. Emergent patients.** Discussions will occur during the discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these conversations in order to expedite discharge.

**1.2.2. Patients who do not have an emergency medical condition.** Following the medical screening, the provider representative will have a discussion with the patient during the registration or discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.

### 1.3. REGISTRATION, INSURANCE VERIFICATION, AND FINANCIAL COUNSELING DISCUSSIONS.

No patient financial discussions will occur before the patient is screened and stabilized, in accordance with EMTALA.

**1.3.1. Registration.** The provider organization will first gather basic registration information, including demographics and insurance coverage, as well as determining the potential need for financial assistance.

**1.3.2. Provision of care.** Patients will be informed that their ability to pay will not interfere with treatment of any emergency medical conditions. Uninsured patients will be informed that the goal of collecting information is to provide a good faith estimate and identify payment solutions or financial assistance options that may assist them with their obligations for this visit in accordance with federal and state transparency and balance billing provisions.

**1.3.3. Insurance verification.** Once screening has occurred and the patient is stabilized, the provider organization will review insurance eligibility information with the patient to ensure information accuracy.

**1.3.4. Financial counseling.** If appropriate, the patient is referred to a financial counselor and/or offered information regarding the provider's financial counseling services and assistance policies.

### 1.4. PATIENT SHARE AND PRIOR BALANCE DISCUSSIONS.

These discussions will occur once the provider organization has fulfilled the previous best practice requirements. Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will take the following actions.

#### 1.4.1. Patient share discussions

**1.4.1.1.** Provide a list of the types of service providers that typically participate in the service, both verbally and in writing in accordance with federal and state regulations.

**1.4.1.2.** Inform the patient that actual out-of-pocket costs may vary from estimates, depending on the actual services performed due to medical necessity or on timing issues with other payments affecting the patient's cost sharing.

**1.4.1.3.** If appropriate, ask if the patient is interested in receiving information regarding payment options.

**1.4.1.4.** If appropriate, ask if the patient is interested in receiving information regarding the provider's financial assistance programs.

**1.4.2. Prior balance discussions.** A balance resolution discussion occurs on prior balances that are being pursued for collection by a provider, collection agency, or other organization. There will be many scenarios where patients will not have prior balances.

**1.4.2.1.** Discuss with the patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient's request, provide the patient a written list of the services provided, dates of service, and the resulting prior balance.

**1.4.2.2.** Ask if the patient is interested in receiving information regarding payment options.

**1.4.2.3.** Ask if the patient is interested in receiving information regarding the provider's supportive financial assistance programs.

**1.4.2.4.** Proactively attempt to resolve prior balances through insurance and financial assistance programs.



**1.5. BALANCE RESOLUTION.** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

**1.6. SUMMARY OF CARE DOCUMENTATION.** During the discharge process, the patient will receive, in writing, information regarding the provider's supportive financial assistance programs, and a summary of the potential financial implications for the services rendered, including a phone number to call with questions.



## SECTION 2.

### BEST PRACTICES AT THE TIME OF SERVICE (OUTSIDE THE EMERGENCY DEPARTMENT)

**2.1. DISCUSSION PARTICIPANTS.** The patient or guarantor will have these discussions with properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine / complex scenarios. Patients should be given the opportunity to request a patient advocate, designee, or family member to assist them in these discussions.

**2.2. SETTING FOR DISCUSSIONS.** The provider organization will have these discussions with patients during the registration or discharge process in a location that does not disrupt patient flow. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.

**2.3. REGISTRATION, INSURANCE VERIFICATION, AND FINANCIAL COUNSELING DISCUSSIONS.** Provider organizations will maintain a thread of pre-registration discussions that occurred with the patient. If pre-registration discussions took place, these discussions will not occur again, unless requested by the patient or guarantor.

**2.3.1. Registration.** The provider organization will first gather basic registration information, including demographics and insurance coverage, as well as determining the potential need for financial assistance.

**2.3.2. Insurance verification.** The provider organization will review insurance eligibility details with the patient to provide good faith estimates to ensure information accuracy. Uninsured patients will be informed that the goal of collecting information is to identify payment solutions or financial assistance options that may assist them with their obligations for this visit. Out-of-network items and services will be addressed in accordance with federal and state balance billing regulations by the provider's financial assistance team.

**2.3.3. Financial counseling.** If appropriate, the patient is referred to a financial counselor and/or offered information regarding the provider's financial counseling services and assistance policies.

**2.4. PROVISION OF CARE.** Provider organizations will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective procedures. They will also have clear definitions for elective and non-elective procedures. These policies will be made available to the public.

**2.4.1. Elective services (as defined by the provider)**

**2.4.1.1. Patient share discussions.** Patients have the obligation to make satisfactory payment arrangements before receiving care.

**2.4.1.2. Prior balance discussions.** Patients with prior balances will be informed by the provider organization if the provider's policies regarding prior balances mean the service will be deferred.

**2.4.2. Non-elective services (as defined by the provider)**

**2.4.2.1.** Patients will be informed that ability to resolve patient share or any prior balances will not affect provision of care.

**2.5. PATIENT SHARE AND PRIOR BALANCE DISCUSSIONS.**

Discussions will not interfere with patient care and will focus on patient education. During patient share and prior balance discussions, the provider representative will take the following actions.

**2.5.1. Patient share discussions**

**2.5.1.1.** Provide a list of the types of service providers that typically participate in the service, both verbally and in writing in accordance with federal and state requirements.

**2.5.1.2.** Inform the patient that actual out-of-pocket costs may vary from estimates depending on the actual services performed due to medical necessity or timing issues with other payments affecting the patient's cost sharing.

**2.5.1.3.** If appropriate, ask if the patient is interested in receiving information regarding payment options.

**2.5.1.4.** If appropriate, ask if the patient is interested in receiving information regarding the provider's financial assistance programs.

**2.5.2. Prior balance discussions.** Balance resolution discussions occur on prior balances that are being pursued for collection by a provider, collection agency, or other organization. There will be many scenarios where patients will not have prior balances.

**2.5.2.1.** Discuss with the patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient's request, provide the patient a written list of the services provided, dates of service, and the resulting prior balance.

**2.5.2.2.** If appropriate, ask if the patient is interested in receiving information regarding payment options.

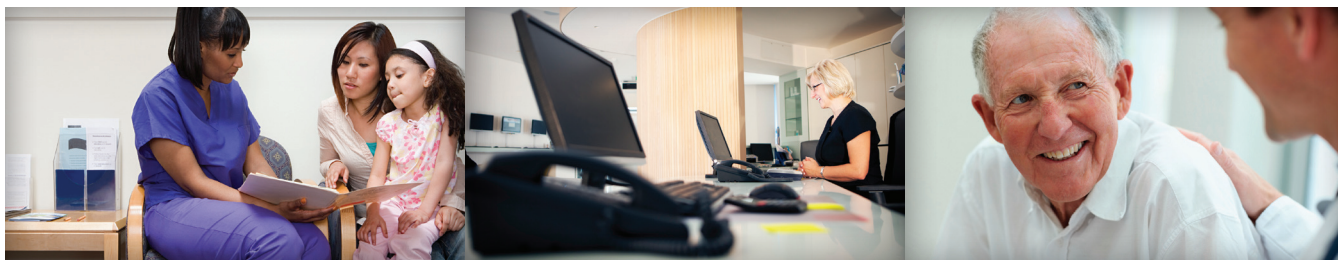
**2.5.2.3.** If appropriate, ask if the patient is interested in receiving information regarding the provider's supportive financial assistance programs.

**2.5.2.4.** Proactively attempt to resolve prior balances through insurance and financial assistance programs.

**2.6. BALANCE RESOLUTION.** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

**2.7. SUMMARY OF CARE DOCUMENTATION.** During the registration or discharge process, the patient will receive in writing, information regarding the provider's supportive financial assistance programs, and a summary of the potential financial implications for the services rendered, including a phone number to call with questions.





## SECTION 3. BEST PRACTICES IN ADVANCE OF SERVICE

**3.1. DISCUSSION PARTICIPANTS.** Appropriately trained provider representatives will have these discussions with the patient or guarantor. Patients should be given the opportunity to request a patient advocate, designee, or family member to assist them in these discussions.

**3.2. SETTING FOR DISCUSSIONS.** Discussions will occur using the most appropriate means of communication for the patient. These discussions may take place via:

- Outbound contact to patient in advance of a scheduled service
- Inbound contact from patient inquiring about their upcoming service
- Scheduling/Contact center when appointment is made

**3.3. TIMING OF DISCUSSIONS.** A reasonable attempt will be made for discussions with patients to occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions and good faith estimates issued in accordance with federal and state regulations will ensure patients understand their financial obligation and providers are aware of the patient's ability to pay and/or source of payment.

**3.4. REGISTRATION, INSURANCE VERIFICATION, AND FINANCIAL COUNSELING DISCUSSIONS.** Provider organizations will maintain a thread of pre-registration discussions that occurred with the patient. If pre-registration discussions took place, these discussions will not occur again, unless requested by the patient or guarantor.

**3.4.1. Registration.** The provider organization will first gather basic registration information, including demographics and insurance coverage, as well as determining the potential need for financial assistance.

**3.4.2. Insurance verification.** The provider organization will review insurance eligibility with the patient to ensure information accuracy. Uninsured patients will be informed that the goal of collecting information is to provide good faith estimates and identify payment solutions or financial assistance options that may assist them with their obligations for this visit. Out-of-network items and services will be addressed in accordance with federal and state balance billing regulations by the provider's financial assistance team.

**3.4.3. Financial counseling.** If appropriate, the patient is referred to a financial counselor and/or offered information regarding the provider's financial counseling services and assistance policies.

**3.5. PROVISION OF CARE.** Provider organizations will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective procedures. They will also have clear definitions for elective and non-elective procedures. These policies will be made available to the public.

#### **3.5.1. Elective services (as defined by the provider)**

**3.5.1.1. Patient share discussions.** Patients have the obligation to make satisfactory payment arrangements before receiving care.

**3.5.1.2. Prior balance discussions.** Patients with prior balances will be informed by the provider organization if the provider's policies regarding prior balances mean the service will be deferred.

#### **3.5.2. Non-elective services (as defined by the provider)**

**3.5.2.1.** Patients will be informed that ability to resolve patient share or any prior balances will not affect provision of care.

**3.6. PATIENT SHARE AND PRIOR BALANCE DISCUSSIONS.** Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will take the following actions.

#### **3.6.1. Patient share discussions.**

**3.6.1.1.** Provide a list of the types of service providers that typically participate in the service, both verbally and in writing in accordance with federal and state regulations.

**3.6.1.2.** Inform the patient that actual out-of-pocket costs may vary from estimates, depending on the actual services performed due to medical necessity or timing issues with other payments affecting the patient's cost sharing.

**3.6.1.3.** If appropriate, ask if the patient is interested in receiving information regarding payment options.

**3.6.1.4.** If appropriate, ask if the patient is interested in receiving information regarding the provider's financial assistance programs.

**3.6.2. Prior balance interactions discussions.** A balance resolution discussion occurs on prior balances that are being pursued for collection by a provider, collection agency, or other organization. There will be many scenarios where patients will not have prior balances.

**3.6.2.1.** Discuss with the patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient's request, provide the patient a written list of the services provided, dates of service, and the resulting prior balance.

**3.6.2.2.** If appropriate, ask if the patient is interested in receiving information regarding payment options.

**3.6.2.3.** If appropriate, ask if the patient is interested in receiving information regarding the provider's supportive financial assistance programs.

**3.6.2.4.** Proactively attempt to resolve prior balances through insurance and financial assistance programs.

**3.7. BALANCE RESOLUTION.** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.



## SECTION 4. BEST PRACTICES FOR ALL SETTINGS

**4.1.** Compassion, patient advocacy, and education should be part of all patient discussions.

**4.2.** Providers should have standard language to guide staff on the most common types of patient financial discussions.

**4.3.** Where appropriate, provider organizations should utilize face-to-face discussions to facilitate one-time resolution.

**4.4.** Availability of supportive financial assistance should be communicated to patients. Provider organizations should communicate and make financially supportive policies available to the community.

**4.5.** The service provider should take the initiative to communicate with the patient.

**4.6.** All personnel engaging in patient financial discussions (e.g., registration staff, financial counselors, financial clearance representatives, and customer service staff) will receive annual training on the following:

- Patient Financial Communications Best Practices
- Financial assistance policies
- Common coverage solutions for the uninsured and underinsured
- Customer service

**4.7.** Provider organizations should ensure broader education and awareness of the Patient Financial Communications Best Practices throughout their organization.

**4.8.** Provider organizations should include the perspective of a patient when developing standard language used in patient financial discussions.

**4.9.** Providers should regularly survey their patients to assess performance against the Patient Financial Communications Best Practices. Results should be shared with staff and leadership for continuous improvement opportunities.

**4.10.** Communication should be understandable by the patient.

**4.11.** Communication should include verification of patient information (mailing address, phone numbers, email, etc.) and the patients' preferred methods for future communication.

**4.12.** Providers should have technology that gives financial representatives up-to-date information about patient balances and financial obligations.

**4.13.** In all patient financial discussions, patient privacy should be respected and conversations should occur in a location and manner that are sensitive to the patient's needs.

**4.14.** Elective procedures should be defined by individual provider organizations to ensure patients are properly informed regarding their financial obligations.

**4.15.** Providers should have a toll-free number and patient self-service tools that are widely publicized that patients can use to receive assistance in financial matters and concerns they may have.

**4.16.** Provider organizations will have clear policies regarding the handling of patients with prior balances. These policies will be made available to the public.

**4.17.** Patient discussions will focus on steps toward amicable resolution of financial obligations.



## SECTION 5. MEASUREMENT CRITERIA

Following are criteria for evaluating the effectiveness of patient financial communications in a healthcare organization. HFMA offers a [recognition program](#) so organizations can demonstrate their implementation of the practices.

### 5.1. TRAINING PROGRAM EVALUATION

**5.1.1.** All staff, including Patient Access, Financial Counseling, and Customer Service staff dealing with patient financial discussions should go through training on an annual basis.

**5.1.2.** Evidence that training occurred is presented to the executive leadership team on an annual basis.

**5.1.3.** Training can be provided through a variety of forums (e.g., web-based or in-person).

**5.1.4.** Training can be provided by qualified resources (internal or external) as deemed appropriate by a designated quality officer (e.g., Compliance, Quality, or Human Resources).

**5.1.5.** Training must cover:

- Patient Financial Communications Best Practices specific to the staff role
- Financial assistance policies
- Available patient financing options

- Alternative solutions for the uninsured
- Standard language to be used in patient discussions
- Laws and regulations (e.g., EMTALA, Fair Debt Collections Practices Act, Telephone Consumer Protection Act, provisions of the Health Care Price Transparency Act of 2023 and No Surprises Act, etc.) specific to the staff role.

### 5.2. PROCESS COMPLIANCE EVALUATION

**5.2.1.** Ensure provider organization is compliant with the Best Practices through annual observation, monitoring, and tracking of results.

**5.2.2.** The evaluation will be comprehensive and cover all relevant parts of the Patient Financial Communications Best Practices.

**5.2.2.1.** Best Practice Scenario 1-Patient Financial Communications in the Emergency Department

- Registration
- Patient share
- Prior balance

**5.2.2.2.** Best Practice Scenario 2–Patient Financial Communications in Advance of Service

- Good faith estimate, as applicable
- Registration
- Patient share
- Prior balance

**5.2.2.3.** Best Practice Scenario 3–Patient Financial Communications at the Time of Service (Outside the Emergency Department)

- Registration
- Patient share
- Prior balance

**5.2.2.4.** Best Practice Scenario 4–Best Practices for all Patient Financial Interactions

**5.2.3.** Process compliance evaluation can be performed by any organization independent of the department being audited (e.g., internal audit, compliance, quality, or a third party).

**5.2.4.** A report containing the results of the process evaluation is presented to the executive leadership team on an annual basis.

### 5.3. TECHNOLOGY EVALUATION

**5.3.1.** Ensure technology is in place to support informing the patient of the following:

- Verification of insurance eligibility for current services
- Verification of existing prior balance within organizational control
- Estimated cost of the current services and the consumer responsibility portion

**5.3.2.** A report containing the results of the technology evaluation is presented to the executive leadership team on an annual basis. The technology evaluation can be performed by any qualified individual or organization (e.g., technology, compliance, quality, or a third party).

### 5.4. FEEDBACK PROCESS AND RESPONSE EVALUATION

**5.4.1.** Ensure process is in place to regularly solicit input and receive feedback from key stakeholders in compliance with Patient Financial Communications Best Practices (e.g., community, patient surveys, physicians).

**5.4.2.** Ensure process is in place to measure and respond to input and feedback received.

**5.4.3.** Ensure provider organization has an escalation process for patient complaint resolution.

**5.4.4.** A report detailing the feedback and response process that is in place and a summary of the feedback and responses that have been exchanged is presented to the executive leadership team on an annual basis.

### 5.5. EXECUTIVE LEVEL METRICS REPORTING EVALUATION

**5.5.1.** Ensure process is in place to consolidate the reports from the four areas listed above into an overall Compliance Report and presented to the executive leadership team on an annual basis.



# Frequently Asked Questions

## What are the Patient Financial Communications Best Practices?

The Best Practices are a comprehensive set of voluntary guidelines that apply to financial conversations with patients in all care settings. Topics addressed by the best practices include when and where financial conversations may be conducted, who should participate, what topics should be covered, and guidance for discussing issues such as financial assistance and prior balances.

## How were the Best Practices developed?

HFMA convened a task force representing consumers, hospitals, physicians, health plans, and other stakeholders to serve as a steering committee. The task force used a consensus process in its monthly meetings to develop the best practices over the course of a year. Their work was informed by public comments.

## What is Adopter recognition?

Adopter recognition is designed as a way for healthcare providers to demonstrate their commitment to excellence in patient financial communications. The recognition is based on HFMA's review of an application and supporting documents that describe an organization's practices. It's a self-attestation process; no on-site review is involved. The recognition is valid for three years.

## Who is eligible to apply for Adopter recognition?

All healthcare provider organizations may apply. Applications may be at the individual provider level or at the system level. For example, a hospital system consisting of three hospitals may complete one application for the system, or may apply using separate applications for each individual hospital. A physician group practice, however, would apply on behalf of the entire group.

## What is the cost to apply?

There is no fee to apply or to receive Adopter recognition.

## What communications tools and support are available to Adopter organizations?

Adopters receive a Communications Toolkit with a sample press release, newsletter article, web copy, emails for employees and Board members, and social media posts. Adopters may use the phrase "Supporter of the Patient Financial Communications Best Practices" in their marketing materials. They also receive a certificate suitable for framing and display. Adopter organizations will be listed on [HFMA's website](#).

## How can we assess our readiness to apply for Adopter recognition?

Use the checklist on page 17 as a self-assessment. Doing this self-assessment can help you identify areas for improvement, whether or not you plan to apply for Adopter recognition.

## How do we get started?

Visit [hfma.org/adopter](https://hfma.org/adopter) and follow the link to "apply now." Once started, you may save your application and resume working on it at your convenience. Your information will be saved.

## What information will I need in order to complete the application?

- ▶ Basic demographic information, including the names and National Provider Identifiers of all entities included in the application
- ▶ Volume data, including:
  - Number of staffed beds
  - Number of employed physicians
  - Annual inpatient discharges
  - Annual ED visits
  - Annual outpatient visits
  - Annual patient encounters (for physician organizations)
  - Annual net patient service revenue

- ▶ Descriptions of patient access workflows in the Emergency Department, at time of service, and in advance of service
- ▶ Policies and procedures for patient access activities in these settings
- ▶ Names and functionality of technology tools used for insurance verification eligibility, calculation of patient's financial responsibility, identification of prior balances due, and other tools such as desktop receipting/cashiering, electronic service authorization, etc.
- ▶ Description of patient satisfaction surveys and other methods used for gathering patient feedback about financial communications processes
- ▶ Description of your training program for new and existing staff in Emergency Department, Patient Access, Financial Counseling, and Customer Service who deal with patient financial communications, including your training policy and procedures, the annual training plan, and annual training requirements for staff and managers.

### How long will it take to receive an answer after we submit our application?

Once your application is complete, you will find out if you qualify for Adopter status within 15 business days.

### What happens if we don't qualify for Adopter status?

Your application will not be formally declined. We will let you know specific suggestions that your organization may choose to implement to meet the criteria. Your application will remain open for a period of six months after you receive our feedback. During that period, you may choose to provide the additional information or make the suggested changes to qualify for Adopter recognition. If you take no action during that period, your application will be dropped from the HFMA database and you will need to reapply.

### We're not ready to apply for Adopter recognition. How can we improve our approach to patient financial communications?

HFMA offers a Patient Financial Communications Training Program, a complete online training solution based on the best practices. Designed for staff who have financial conversations with patients, the program features scenario-based conversations so staff can address difficult patient financial conversations in a confident, caring, and supportive way - while enhancing overall patient satisfaction. The program allows learners to work at their own pace, 24/7, and includes an online toolkit with sample financial policies, feedback tools, and effective job aids. More information is available at [hfma.org/dollars](https://hfma.org/dollars).

What are some of the topics covered in the program?

- ▶ Conducting financial discussions effectively, both in person and on the phone
- ▶ Communicating effectively with patients who are stressed, confused, or dissatisfied
- ▶ Helping patients understand their financial obligations
- ▶ Serving as a resource for patients about financial and insurance matters relating to healthcare services
- ▶ Explaining key terms to patients
- ▶ Providing information about payment options
- ▶ Using appropriate verbal and nonverbal communication styles

# Checklist: Is Your Organization Ready to Apply for Adopter Recognition?

Check the boxes for items that apply to your organization. If you can check most of the boxes on this list, your organization is well positioned to apply for and receive recognition as an Adopter of the Best Practices for Patient Financial Communication. If some of these items don't yet apply to your organization, you have identified areas for improving your approach to patient financial communication. HFMA offers an online training program that can help. For more information, visit [hfma.org/dollars](https://hfma.org/dollars).

- 1.** We have a written policy and procedures to govern patient access activities related to patient financial communications in the following situations and settings:
  - ☐ **a.** Emergency department
  - ☐ **b.** Unscheduled (walk-in) patients at the time of service
  - ☐ **c.** Advance of service
- ☐ **2.** Our financial policies specify what to do in the case of patients who have a prior balance when they present for and/or schedule care.
- ☐ **3.** We have a toll-free number that is widely publicized that patients can call to receive assistance with financial matters and concerns.
- 4.** I agree with the following statements:
  - ☐ **a.** Compassion, patient advocacy, and education are a part of all patient communications at my organization.
  - ☐ **b.** We use standard language to guide staff on the most common types of patient financial communications.
  - ☐ **c.** Face-to-face communications are used appropriately to facilitate one-time resolution.
  - ☐ **d.** Availability of supportive financial assistance is always communicated to the patient and the community.
  - ☐ **e.** We initiate financial communication with patients.
  - ☐ **f.** We include the patient's perspective in the development of the standard language used for patient financial communications.
  - ☐ **g.** We routinely verify patient information and the patient's preferred methods for future communication.
  - ☐ **h.** We respect patient privacy in all financial communications.
  - ☐ **i.** All of our patient financial communications focus on steps toward amicable resolution of financial obligations.
- 5.** We have technology solutions in place to support the following functions:
  - ☐ **a.** Insurance verification eligibility
  - ☐ **b.** Estimation to calculate the patient's responsibility for services
  - ☐ **c.** Identification of prior balances due
- ☐ **6.** We have a process in place to assess our performance in areas related to patient financial communications.

☐ **7.** We have a training program in place for staff in the Emergency Department, Patient Access, Financial Counseling, and Customer Service who deal with patient financial communications.

**8.** We can provide recent year-end data on the following performance metrics (definitions and sources will be provided):

☐ **a.** Net days in accounts receivable

☐ **b.** Point-of-service cash as a percentage of total patient cash

☐ **c.** Insurance verified encounters as a percentage of total encounters

☐ **d.** Pre-registered encounters as a percentage of scheduled encounters

☐ **9.** Our CFO or Vice President of Revenue Cycle will attest to the accuracy of the information we submit in our application.



healthcare financial management association

The Healthcare Financial Management Association (HFMA) equips its members nationwide to navigate a complex healthcare landscape. Finance professionals in the full range of work settings, including hospitals, health systems, physician practices and health plans, trust HFMA to provide the guidance and tools to help them lead their organizations, and the industry, forward. HFMA is a not-for-profit, nonpartisan organization that advances healthcare by collaborating with other key stakeholders to address industry challenges and providing guidance, education, practical tools and solutions, and thought leadership. We lead the financial management of healthcare.

**Healthcare Financial Management Association**

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