CONSUMER COMPLAINT FORM

Office of the Indiana Attorney General

To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. **DO NOT** include your **Social Security Number** on this form or in any accompanying documents.

1. YOUR INFORMATION

☒ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Name Brian Kahn

Address

City State IN

ZIP 46074 County Hamilton

Age ☐ 18-24 ☐ 25-34 ☒ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+

Phone Day

Are you or your spouse active military? ☐ Yes ☒ No

E-mail

2. WHO IS YOUR COMPLAINT AGAINST?

Name/Firm St. Vincent Hospital and Health Services

Address 10330 N Meridian Street, Suite 200

City Indianapolis State IN

ZIP 46290 County Marion

Phone (317) 338-8035

E-mail

Person you dealt with

3. WHEN DID TRANSACTION/INCIDENT OCCUR? Date September 2012

4. WHERE DID THE TRANSACTION/INCIDENT YOU ARE COMPLAINING ABOUT TAKE PLACE? (Check box when applicable)

- ☒ At the firm's place of business
- ☐ My home
- ☐ Away from the firm's place of business (work, convention, etc.)
- ☐ Other
- ☐ By Mail
- ☐ By Internet/e-mail
- ☐ By telephone

5. WHAT WAS THE VERY FIRST CONTACT BETWEEN YOU AND THE FIRM?

- ☐ I telephoned the firm
- ☐ I responded to a TV/radio ad
- ☐ A person came to my home
- ☐ I received information by e-mail
- ☐ I received information in the mail
- ☐ I went to the firm's place of business
- ☐ I received a telephone call from the firm
- ☐ I responded to an offer on the Internet
- ☐ I responded to a printed advertisement
- ☒ Other referred by doctor

6. DO YOU CONSENT TO DISCLOSING THE FOLLOWING TO THE PUBLIC?

The nature and status of your complaint and the name of the firm?	☒ Yes	☐ No
Your name?	☒ Yes	☐ No
Your phone number?	☐ Yes	☒ No

7. WHAT WAS THE TRANSACTION FOR?

- ☐ My business
- ☒ My family/household
- ☐ My farm

8. HOW DID YOU PAY?

- ☐ Cash
- ☐ Check
- ☐ Credit Card
- ☐ Installment Loan
- ☐ Medicaid
- ☐ Medicare
- ☒ Private Insurance
- ☐ Other

9. DID YOU SIGN ANY WRITTEN AGREEMENT? IF YES, PLEASE ATTACH A COPY OF THE AGREEMENT. ☒ Yes ☐ No

For Office Use Only:

Ind	Prac	PL MO NL NJ	OA:	Inv.	Sec	File #
						-CP-

10. HAVE YOU COMPLAINED TO THE BUSINESS? (Check box when applicable) ☒ Yes ☐ No

When? November 2012, December 2012, January 2013 Action taken? no response

11. WITH WHAT OTHER AGENCY HAVE YOU FILED THIS COMPLAINT? none

When? Action taken?

12. HAVE YOU CONTACTED A PRIVATE ATTORNEY? ☐ Yes ☒ No

13. HAVE YOU STARTED A COURT ACTION? IF YES, PLEASE ATTACH A COPY OF ALL COURT PAPERS. ☐ Yes ☒ No

14. HAVE YOU BEEN SUED OVER THIS ISSUE? IF YES, PLEASE ATTACH A COPY OF ALL COURT PAPERS. ☐ Yes ☒ No

15. DOLLAR AMOUNT ASSOCIATED WITH YOUR LOSS, IF ANY. $ 1,234.96

16. PLEASE DESCRIBE YOUR COMPLAINT IN DETAIL (ATTACH ADDITIONAL PAGES IF NECESSARY)

Please attach a copy of all papers involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence and all other related documents). Please print clearly or type. DO NOT INCLUDE YOUR SOCIAL SECURITY NUMBER.

I was referred to a St Vincent physical therapy office by my doctor. I called my insurance company (Anthem) and they told me I would have a $40 co-pay per visit. At the same time, my wife was having physical therapy for the same issue at a IU Health facility. She was paying $40 per visit. After my first visit, the receptionist said she did not accept payment and wait for the bill in the mail. My first bill charged $646.15 for 3 visits. I immediately called and cancelled all future appointments although I still had 4 additional appointments I had not yet been billed for. The next bill was for $588.81 for 4 more visits, so the total was $1,234.96 for 7 total visits. By calling Anthem and St Vincent, I learned the charges were different because St Vincent was billing the visits as a "Hospital Facility" visit and not an office visit. The visits took place at a 2-story office building with other medical offices there, not in a hospital. If you review the itemized statements I have included, you can see that St Vincent was billing my insurance company almost the exact same as IU Health was billing for my wife, but because St Vincent coded these charges as "Hospital Facility" they are able to charge both my insurance company and me more money. How are they able to charge more for the same services? At my first appointment, they had me sign a form that, among other things, stated they billed as a Hospital Facility, but they don't tell you that it means you will pay more. I only found that out after I received the bills. How should consumers know that? I had already asked my insurance company if I was covered and they told me I was.

I wrote a letter to St Vincent disputing the charges November 6, 2012. I called to follow up on November 30 and I was told I would hear back in 2-3 weeks. I called again December 18, 2012 and was told a supervisor "Chris" would return my call. After no call, I called again January 16, 2013 and was again told Chris would return my call.

17. HOW WOULD YOU LIKE YOUR COMPLAINT RESOLVED?

I would like the bills adjusted to reflect $40 per visit.

18. CONSENT AND VERIFICATION

I affirm, under the penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement.
I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).

Your Signature Date 1/17/13

WHAT WILL HAPPEN NOW? WHAT ELSE SHOULD YOU DO?

The Consumer Protection Division will send a copy of your complaint to the respondent firm or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

MAIL COMPLETED FORMS TO:

Attorney General Greg Zoeller
Consumer Protection Division
Government Center South, 5th floor
302 West Washington Street
Indianapolis, IN 46204
PH: 317-232-6330 • FAX: 317-233-4393
www.IndianaConsumer.com

St. Vincent Hospital and Health Services
2001 West 86th Street
P.O. Box 40970
Indianapolis, IN 46240-0970

ADDRESS SERVICE REQUESTED

Account Number	Statement Date	Amount Due
	01/10/13	$646.15
Patient Name		**Date Due**
BRIAN E KAHN		01/20/13

AMOUNT PAID $

Please write account number on check.

CHECK NUMBER:

ACCOUNT NUMBER

SIGNATURE

EXP DATE

CVV2

AMERICAN EXPRESS VISA DISCOVER

**********AUTO**3-DIGIT 460
MB1-1-L706 2-2-305 726
BRIAN E KAHN
CARMEL IN 46074-2311

00706

Pay by Credit Card or Make Check Payable to

ST. VINCENT HOSPITAL AND HEALTH SERVICES
9600 RELIABLE PARKWAY
CHICAGO, IL 60686-0096

*KAHN****BRIA011113***646151

☐ PLEASE CHECK HERE AND SHOW ADDRESS CORRECTION ON REVERSE SIDE

<<<< Please fold along perforation and return stub with payment >>>>

St. Vincent
Hospital and Health Services
2001 West 86th Street
P.O. Box 40970
Indianapolis, IN 46240-0970

PAYMENT EXPECTATION

- St. Vincent would appreciate a payment in full when you receive your statement.
- If you are unable to pay in full, we offer payment plans at zero percent interest with no prequalification.
- Financial Assistance is available for those that are unable to pay.
- Contact Customer Service for financial assistance and payment arrangement details.

As a patient of St. Vincent, you have the right to expect the finest level of Health Care. You have many choices for your health care needs and we want to thank you for choosing us. We hope that our services exceeded your expectations.

CUSTOMER SERVICE CONTACT INFORMATION

Monday through Friday
8:00 AM – 4:00 PM
317-338-8035
800-582-8258 toll free
317-583-2737 fax
E-Mail: billing@stvincent.org

To Pay Your Bill Online Please Go To:
www.stvincent.org

SUMMARY OF SERVICE FOR

BRIAN E KAHN

SERVICE DATE	09/20/12	STATEMENT DATE	01/10/13

Rehabilitation Therapy	1095.00
Total Charges	**1095.00**

ACCOUNT ACTIVITY

Negotiated Insurance Discount	-448.85
Deductible / Copay Due	
Total Payments/Discounts	**-448.85**

Final Notice

Account Number	Due Date	Amount Due
	01/20/13	$646.15

FINAL NOTICE - PLEASE CONTACT US IMMEDIATELY - FINAL NOTICE

St. Vincent offers a **guaranteed, zero percent interest, and no application required** payment plan through our partner Torre Pines Bank. Torre Pines is **not** a collection agency and there will be no impact on your credit. Please contact Customer Service **now** to take advantage of this opportunity and avoid being placed with a collection agency.

112612 Page 1 of 2

St. Vincent Hospital and Health Services
2001 West 86th Street
P.O. Box 40970
Indianapolis, IN 46240-0970
ADDRESS SERVICE REQUESTED

Account Number	Statement Date	Amount Due
	11/26/12	$588.81
Patient Name		**Date Due**
BRIAN E KAHN		12/17/12

AMOUNT PAID $

Please write account number on check.

CHECK NUMBER:

ACCOUNT NUMBER

SIGNATURE

EXP DATE

CVV2

☐ ☐ ☐ ☐

**********AUTO**3-DIGIT 460
MB1-1-L368 1-1-373 374
00368 BRIAN E KAHN

CARMEL IN 46074-2311

Pay by Credit Card or Make Check Payable to

ST. VINCENT HOSPITAL AND HEALTH SERVICES
9600 RELIABLE PARKWAY
CHICAGO, IL 60686-0096

AHN****BRIA112712***588819

☐ PLEASE CHECK HERE AND SHOW ADDRESS CORRECTION ON REVERSE SIDE

<<<< Please fold along perforation and return stub with payment >>>>

St. Vincent
Hospital and Health Services
2001 West 86th Street
P.O. Box 40970
Indianapolis, IN 46240-0970

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E-Mail: billing@stvincent.org

To Pay Your Bill Online Please Go To:
www.stvincent.org

SUMMARY OF SERVICE FOR

BRIAN E KAHN

SERVICE DATE	10/01/12	STATEMENT DATE	11/26/12

Rehabilitation Therapy	1063.00
Total Charges	**1063.00**

ACCOUNT ACTIVITY

Negotiated Insurance Discount		-435.74
Payment Anthem	11/15/12	-38.45
Deductible / Copay Due	11/15/12	
Coinsurance Due		
Total Payments/Discounts		**-474.19**

1, 4, 12, 16

Account Number	Due Date	Amount Due
	12/17/12	$588.81

BALANCE REMAINING AFTER INSURANCE - PAYMENT NOW DUE

We have been advised that your insurance will not be paying the remaining balance on your account. If you question this information- Please contact your insurance company. Please pay the amount in full by 12/17/12 or contact Customer Service to take advantage of our zero percent interest payment plans.

Brian E. Kahn, Esq.

Carmel, IN 46074

November 6, 2012

St. Vincent Hospital
Attn: Auditor
10330 North Meridian
Suite 200
Indianapolis, IN 46240

VIA FAX (317-583-2737) AND US MAIL

Re: Acct#1081077610

Dear Auditor,

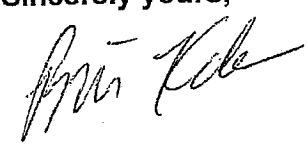
I am writing to request an appeal be opened on my account. I feel that the rehabilitation office I went to to receive therapy, and which is affiliated with you, has misrepresented themselves. When I knew I needed therapy, I asked my doctor for a referral as well as calling my insurance company to see if they would authorize it. They said I would be responsible for a $40 copayment for each visit and that they covered rehab services. Imagine my surprise when I get a bill for $646.15 for three visits instead of $40 per visit. Upon investigation, I find that you are billing not as an office entity but as a hospital. My wife has recently gone to rehab therapy at Methodist Medicine Center. They billed as an office entity and she paid a $40 copayment each time she went.

I called my insurance company and they stated instead of reflecting the place of service as an office, you state it is a hospital when billing for services. When I compare the bills side by side, I can see that if you bill as a hospital you are recouping more monies than Methodist is collecting. Thus, you are billing the hospital portion of my insurance rather than the medical service provider portion of my insurance. To me this a flagrant mis-representation. I am enclosing a photo of the medical office building marquis where I went to physical therapy. It states it is a medical office building, not a hospital. There are Physicians and other medical providers in this building also attached to the hospital but they bill as an office entity, which I have learned from their patients.

I am asking that these services be charged to me at $40 per office visit and not under the hospital portion of my contract. The insurance company said they would be happy to review and adjust a new claim based on this information. I am absolutely appalled that your institution would totally mis-represent themselves in this fashion to a patient/patients. To me it is dealing with clients in "bad faith" and should be stopped as well as investigated.

Do be assured that I feel I am completely justified on this review and will take it to an external appeal if necessary. I own a business in town and will use all the resources I have available to me to correct this fraudulent activity.

Sincerely yours,



Brian E. Kahn, Esq.

Cc: St. Vincent Hospital and Health Services
9600 Reliable Parkway
Chicago, IL 60686-0096

Michigan Road Medical Office Building

St. Vincent Imaging Center 100

St.Vincent Medical Group 100
Family Medicine
Charles Campbell, MD
Chad Chin, MD
Louis E Ramos, MD

Pediatrics
Jim Meyers, MD
Kate Pedersen, MD
Gum Bansi, MD

Internal Medicine 100
Paige Hulk, MD

SightEyes Optical Boutique 100
Angela N. Bagnall, OD
Independent Doctor of Optometry
Vivek Agrawal, MD

Endocrinology 100
Elizabeth Overton, MD
Jeremy Gropp, MD

Immediate Care 150

St. Vincent Outpatient 200
Radiation Services
Radiology and Healthy Aid Services
Physical Therapy

Indiana Oral and Maxillofacial 201
Surgery Associates
Jeffrey D. Bulaum, DDS
J. Jeffrey Hopkins, DDS
Christopher T. Kraus, DDS, MS

St.Vincent Medical Group 205
Internal Medicine
Paul J. Hanna, MD

Sycamore Smiles Pediatric Dentistry 210
Jennifer Bakerlad-Siegel, DDS 210

St. Vincent Pediatric Orthodontic 240
Center & Orthodontic Program
Ronald R. Hathaway, DDS, MS

Managed by Duke Realty
for Senior Care Health-Care

1

ST VINCENT HOSP & HEALTH CARE CT
2001 W 86TH STREET
INDIANAPOLIS,IN
317 338-8035

FED ID 35086 90

46260

PAGE NO. 1

HOSP. NO. 000000

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL
09 OUTP.	10/05/12	

FEDERAL I.D. NUMBER 35086 90

PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
3 D KAHN, BRIAN EVAN		M	35	09/20/12		

GUARANTOR NAME AND ADDRESS
GUAR PH: (317)500-0950
BRIAN EVAN KAHN
WESTFIELD IN 46074

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	BLUE CROSS	2	

POSTING DATE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
	DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS							
09/20	001MANUAL THERAPY58780510		143.00	143.00				
09/20	001PT EVALUATION 58780561		303.00	303.00				
09/20	001ALT-THERAPEUTI58784125		110.00	110.00				
09/24	001MANUAL THERAPY58780510		143.00	143.00				
09/24	001THERAPEUTIC EX58780650		110.00	110.00				
09/26	002MANUAL THERAPY58780510		286.00	286.00				
	BALANCE FORWARD		0.00					
	SUMMARY OF CURRENT CHARGES							
	REHAB SERVICES		1095.00	1095.00				
	SUB-TOTAL OF CURR. CHARGES		1095.00	1095.00				
	IF YOU HAVE INSURANCE YOUR BENEFITS ARE ASSIGNED TO US. THANK YOU FOR CHOOSING ST. VINCENT FOR YOUR HEALTH CARE NEEDS.							
	T O T A L S		1095.00	1095.00		PAY THIS AMOUNT		0.00

ST VINCENT HOSP & HEALTH CARE CT FED ID
INDIANAPOLIS,IN

PATIENT NUMBER

MAKE CHECKS PAYABLE TO:

Methodist Sports Medicine Center
PO Box 856300
Dept 122
Louisville, KY 40285-6300

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT ☐ DISCOVER ☐ MASTERCAR ☐ VISA		
CARD NUMBER	CVV	AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
10/24/12	$0.00	
	SHOW AMOUNT PAID HERE	$

STATEMENT

ADDRESSEE:

Kahn, Emily E

Carmel, IN 46074

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

REMIT TO:

Methodist Sports Medicine Center
PO Box 856300
Dept 122
Louisville, KY 40285-6300

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT
www.methodistsports.com
(317) 817-1200

DATE	PATIENT	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	CHARGE	INSUR RECEIPT	PATIENT RECEIPT	ADJUST	INSUR BALANCE	PATIENT BALANCE
08/22/12	Emily	Smerek...	73630	*Foot, 3 V = AP, Lateral And ...	$90.00	$30.31		$59.69	$0.00	$0.00
08/22/12	Emily	Smerek...	99203	OFFICE/OUTPATIENT VISI...	$263.00	$63.29	$40.00	$159.71	$0.00	$0.00
08/22/12	Emily	Smerek...	73630	*Foot, 3 V = AP, Lateral And ...	$90.00	$30.31		$59.69	$0.00	$0.00
08/30/12	Emily	Carroll PT	97110	THERAPEUTIC EXERCISES	$170.18	$41.10		$129.08	$0.00	$0.00
08/30/12	Emily	Carroll PT	97001	PT EVALUATION	$207.74	$29.34	$40.00	$158.40	$0.00	-$20.00
09/10/12	Emily	Carroll PT	97140	MANUAL THERAPY	$65.18	$19.19		$45.99	$0.00	$0.00
09/10/12	Emily	Carroll PT	97110	THERAPEUTIC EXERCISES	$85.09	$0.55	$40.00	$64.54	$0.00	-$20.00
09/12/12	Emily	Smerek...	L4396	Static AFO	$233.00	$84.47		$127.41	$0.00	$21.12
09/28/12	Emily	Carroll PT	97110	THERAPEUTIC EXERCISES	$170.18	$21.10	$40.00	$129.08	$0.00	-$20.00
10/24/12	Emily	Smerek...	99212	OFFICE/OUTPATIENT VISI...	$106.00				$106.00	$0.00

Payment Due Upon Receipt. Thank You.
This is a reminder that your payment is past due. Please call our billing office immediately to discuss payment plan.

ACCOUNT NBR	CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS	TOTAL ACCOUNT BALANCE
–	$86.00	-$18.88	$0.00	$0.00	$0.00	$67.12

MESSAGE:
Thank You For Choosing Methodist Sports Medicine For Your Medical Care.
Please Call 866-942-2687 For Any Billing Questions.

PLEASE PAY
THIS AMOUNT »»»» $0.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

STATEMENT

9/24 7:30
9/28 9:30

KAHN ,BRIAN EVAN 000211-11-53
HELMS, MICHAEL J. 04/21/1977

St. Vincent Rehabilitation Ben

Insurance Company: Anthem

Phone# 888-650-4047 Date: 9/19/12

Who Called: Lenesha Spoke With: Online

Pre Cert Required: NO Pre Cert #

How many visits, 20 PT — OT — SP — Combined — Through date: Calendar Year

Deductible: $ $3,000 Copay $40 Out of Pocket: $ $6,000

Plan pays: 80 % Effective Date: 4/1/12

Exclusions:
Notes:

Initial Entered in TPX: Initial Scanned: Initial Patient given a copy:

Note: Please be advised, we do not accept payments for services at this office. This information is being provided to you as a courtesy. It is **not a guarantee of payment. Your benefits will be determined upon receipt of our claim by your insurance carrier.** You will receive a bill for any outstanding balance that your insurance does not pay as well as any deductibles, co-pays, or co-insurances that you may owe. If you have questions about your coverage, please call your insurance carrier for more information. We bill through St. Vincent as a **HOSPITAL FACILITY** (not as an office visit). We will provide benefit information upon your request, but we are unable to track any charges, credits, payments, deductions, or any other financial activity on your account. **If you would like detailed information about your bill, please contact our billing department at 338-8035.** We appreciate your understanding as this allows us, your therapists, to be more focused on providing excellent care to you.

Patient Signature 9/20/12 Date

Witness Signature 9/20/12 Date

Revised 5/16/12