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ADVISOR

Consider collection agency to handle delinquent accounts

When to send accounts to a collection agency is an increasingly important decision as payers shift more of the financial responsibility for healthcare services onto patients and hospital and physician practices struggle to collect growing out-of-pocket payments.

“In terms of collections, we’re going to have some horrible times coming down the road,” says **Owen J. Dahl, FACHE, CHBC**, president of Owen Dahl Consulting in The Woodlands, TX, and author of *Think Business! Medical Practice Quality, Efficiency, Profits*. “We’re seeing an emphasis on higher-deductible plans. We’re seeing patients delaying visits to the doctor. All kinds of issues are going to create payment problems, both in the volume and the acuity of activity.”

If you’ve thoroughly examined your in-house processes (see “Make internal fixes before hiring outside agency” on p. 3), consider which accounts to send to a collection agency to pursue payment of those debts.

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Physician practices typically send debts of a certain size or age to an agency to remove them from accounts receivable (A/R). The difference between what the agency collects and the full value of the debt is then written off as a loss.

Time is the most important trigger. Many practices wait too long to contact an agency because the physicians don’t want to give up on their internal collectors and pay a fee, says **Jeffrey N. Hausfeld, MD, MBA, FACS**, managing director of FMS Financial Solutions, a full-service debt recovery firm based in Greenbelt, MD. However, an agency can help practices monitor A/R and

“Practices should look for the ability to influence and customize the collection agency’s approach, both on a global and on an individual basis.”

—Jeffrey N. Hausfeld,
MD, MBA, FACS

examine trends so accounts don’t become stale, Hausfeld says. Hiring a collection agency also frees internal staff members to focus on collecting accurate payments from insurers in a timely fashion.

Ask physicians to establish collections policy

Physician practices should process a patient’s claim within one business day of the service and should expect an explanation of benefits (EOB) from the payer within 30 days. With the EOB in hand, “the clock starts ticking,” Hausfeld says, advising practices to generate a letter to the patient during each of the following three months unless payment is received. At that point, unpaid bills should be sent immediately to a collection agency.

“If a patient hasn’t paid within three months following adjudication of the claim, chances are—and statistics prove this out—the patient doesn’t plan to pay the remaining balance,” Hausfeld says. The patient may think

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the insurer is responsible for the remainder of the bill, have a dispute about the bill, or not have sufficient funds to pay the bill. "In any case, continuing to do the same thing over and over will be fruitless," Hausfeld adds.

To avoid misunderstandings, your physicians should set the group's collections policy and make the final decision on which accounts go to a collection agency. When your practice has followed all of the established collections policies and a patient still refuses to pay, in theory, the account should always go to collections. But recognizing that an account sent to collections may damage a patient's credit rating, physicians may want to use some discretion when a patient or even the referring physician is a close friend or colleague.

"The physician is the authorizer because, in the end, the care is rendered between the physician and the patient,"

says **Janet Marcus, CPC**, senior consultant at Sinaiko Healthcare Consulting, Inc., in Los Angeles. "You don't want a physician to be surprised when an account goes to a collection agency."

However, don't give a doctor 30 patients to review for collections without emphasizing the urgency of the matter. "Tell the doctor, 'If I don't hear back from you in a week, these are going out,'" Hausfeld says.

Structure service agreement to meet your needs

In general, hiring an outside collection agency will cost your practice 25%–35% of the outstanding debt that's recouped. That's a big chunk of change, but an outside agency will have a skill set that your office staff may lack. For example, collection agencies are well versed in the Fair Debt Collection Practices Act of 1977 (FDCPA), a federal law administered by the Federal Trade Commission that limits the hours during which the agency may call the patient and prohibits communication of the debt to a third party. The FDCPA also prohibits false, deceptive, or misleading representations and bars the agency from making threats it cannot legally pursue.

Interview at least three collection agencies to identify one that feels like a good fit with your practice. (See "Consider these questions when evaluating collection agencies" on p. 4.) The relationship between your practice and the agency is governed by a service agreement, which stipulates the amount of the fee and the terms. Once you've selected a candidate, structure your agreement carefully so both parties understand their responsibilities. For example, collection agencies expect accurate information from the practice on debtors and the amount of their debt. In turn, they can offer a smorgasbord of services, from writing letters to pulling credit reports to referring accounts for legal action.

Most medical collection agencies work on a contingency basis, which costs the practice nothing until the

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Make internal fixes before hiring outside agency

The best collections strategy is one you manage in-house, says **Owen J. Dahl, FACHE, CHBC**, president of Owen Dahl Consulting in The Woodlands, TX, and author of *Think Business! Medical Practice Quality, Efficiency, Profits*. “Why would you give up a percentage of your collections if you had a way to collect the money internally?” Dahl says.

Janet Marcus, CPC, senior consultant at Sinaiko Healthcare Consulting, Inc., in Los Angeles, advises physician practices to monitor the volume of four key metrics: mail, accounts with balances less than \$30, self-pay accounts, and accounts with balances greater than \$1,000 that are being sent to collections. “Less is better, so if your practice has small numbers in these four areas, you’re probably doing well in your internal collection efforts,” Marcus says.

Track several other metrics to assess the effectiveness of internal collections:

- ▶ Calculate your gross collections percentage by taking the ratio of charges to payments. Summarize total charges and receipts over a six- or 12-month period, calculate a monthly average, and examine gross collections for that average month, Dahl says. Trend the average forward—examining the monthly average for the 12-month period from January to January, then February to February, etc.—to monitor trends in your collections performance.
- ▶ Calculate your net collections percentage, which adjusts the ratio of charges to payments for contractual and other adjustments. “If all of the insurance adjustments are correct when you look at long-term trends, the net collection percentage should be 100%,” Dahl says. When net collections fall below 100%, the difference represents bad debt. Consider using a collection agency once this percentage hits a predetermined trigger.
- ▶ Calculate average days or months in accounts receivable (A/R) by totaling your average charges over a six- or 12-month period, dividing by the number of months to determine your average monthly charges, then dividing that figure into your total A/R to calculate the number of months those charges are sitting in A/R. Multiply that result by 30 to calculate the days in A/R. Practices that consistently hold their A/R average below 70 days are managing collections efficiently, Marcus says.

- ▶ Track the percentage of A/R dollars greater than 90 days to keep aging accounts below 10%–15% of your total A/R. “If this percentage creeps toward 20%, you should examine which charges are lingering in A/R and why,” Marcus says.

Establish A/R triggers to ensure that you don’t neglect accounts to the point that they become delinquent, Marcus adds. Program your software to monitor the number of statements you send to each patient and flag any accounts that receive multiple statements without submitting a payment. Create a monthly management report that lists all accounts exceeding a certain dollar amount that remain unpaid after initial follow-up.

Practices should understand how to analyze their numbers, Dahl says. Although benchmarking can help you measure your organization against peers and high performers, “the variables in each practice—managed care contracts, workers’ compensation relationships, and legal cases—affect the numbers inside that practice,” he explains.

In addition to watching your A/R metrics, ensure that your collections policies and procedures are up to date. For example, does your practice have a well-defined, written policy that specifies the number of collection letters you will generate, the timing and sequence of those letters, and whether or when you will follow up with a phone call to the patient before sending an account to a collection agency?

Internal procedures should support these policies. Notify patients of copays and outstanding balances when you call to remind them of appointments. Process claims and payments electronically and use authorization and verification modules to improve accuracy.

“If you have thorough practices in place, you’ll decrease the volume of accounts that have to be considered for referral to a collection agency,” Marcus says.

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Collection agency

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agency collects money from a patient. However, an agency may require payment even if it doesn't recover the full amount of the debt or if the practice cancels the collection effort before the debt is collected. Some agencies also acquire portfolios of debt, which may get worked harder while smaller accounts languish. "Every debt that comes to a good collection agency should get attention," Hausfeld says.

Retain the ability not only to negotiate the threshold dollar amounts and age of the charges that are sent to the agency, but also the authority to make final decisions before collections are sent to a credit bureau. Practices need the flexibility to override collection agency procedures in isolated cases, "and that needs to be a frank, open discussion before the contract is signed," Marcus says. The contract also should specify which individuals in the practice may release accounts to the collection agency and which individuals in the agency may file a lawsuit on behalf of the practice.

"Practices should look for the ability to influence and customize the collection agency's approach, both on a global and on an individual basis," Hausfeld says.

Seek an agency that knows customer service

A collection agency has the authority to locate patients, negotiate payment plans, and even extend loans to creditworthy patients. Because each collection agency develops its own strategies to recover payments from patients, "sit down with the collection agency's leadership during the negotiation stage and explain your customer service requirements," Marcus says.

Some agencies are quick to strong-arm customers, whereas others have a softer touch. Some skilled collectors can establish rapport with patients during an initial phone call and work out a payment plan from the get-go. But the time to talk about what tactics are used and your potential influence as a client is when you're still at the courting stage.

Consider these questions when evaluating collection agencies

To find a collection agency that's a good match with your practice, develop a checklist or questionnaire and use the same rigor in evaluating candidates that you would use to interview other types of vendors. The following are questions that **Owen J. Dahl, FACHE, CHBC**, president of Owen Dahl Consulting in The Woodlands, TX, and **Janet Marcus, CPC**, senior consultant at Sinaiko Healthcare Consulting, Inc., in Los Angeles, recommend:

- When was the collection agency established, and what percentage of its business is represented by physician practices?
- Does the agency have experience working with a variety of healthcare services? If so, which ones?
- Does the agency have a local office so it can understand the nuances of your geographic market?
- How does the agency manage customer service relationships with practices and patients?
- What is the agency's experience with workers' compensation claims?
- Does the agency belong to the Better Business Bureau?
- What training does the agency provide for its staff?
- What are the agency's policies with respect to hiring and background checks?
- How are accounts handled when they're referred to the agency: sequentially, by size of the debt, or according to other factors?
- What is the agency's collection success rate, and how is that defined?
- Are payments from patients sent directly to the practice or to the agency? How does the agency settle those payments with the practice?
- Does the agency maintain a suspense file to reexamine accounts that can't be recovered immediately?
- What is the fee schedule? To what extent are fees negotiable based on volume and other factors?
- What additional costs may be incurred in the collections process? For example, if an account goes to trial, does the agency's collection percentage increase?

On the other hand, it's counterproductive to hire an agency and then micromanage its efforts. Although practices want to preserve good relationships with patients, "if you tie the hands of your collection agency, they can't do the job you hire them to do," Dahl says.

During contract negotiations, ask the collection agency to assign a manager to interface with the practice manager. "This gives you a direct source for quick problem solving and for more effective communications," Marcus says. She also advises practice managers to interview some of the staff members who would be assigned to your account. Are they diplomatic, tactful, and solution-oriented? How do they address patient complaints and correct mistakes that may occur during the collections process?

In addition, ask for a sample report that illustrates how the agency will communicate the status of each account. Learn whether the reports will be sorted by type of service and how often they'll be generated. Ask for references at other healthcare organizations and call them to learn about their experiences with the agency.

"We recommend that practices contract with two collection agencies simultaneously," Marcus says. "Distribute the assignments equally to those two agencies, then evaluate and compare the results." Practices that are heavily involved with workers' compensation should find a collection agency that specializes in those services, which are governed by different rules and regulations, she adds.

Consider small claims court, other services

A collection agency isn't your only alternative to address delinquent patient accounts. Most states allow physician practices to pursue patient debts through small claims court, which may be cheaper than a collection agency. Although you may not receive your money right away, filing in small claims court "gives you a leg up" in recovering financial judgments for a modest up-front fee, Dahl says. However, this option requires considerably more oversight by the practice staff, "so you have to weigh the cost versus the benefit," he adds.

Having an attorney simply write collection letters on the law firm's letterhead is another option that may save

your practice time and money. Some collection agencies also offer letter-writing services in which, for a small flat fee, they generate a series of increasingly urgent letters instructing patients to pay the amount owed directly to the creditor or risk a collection action and negative credit report. Hausfeld's firm offers an early recovery program that kicks in three months after the first bill is generated by a practice. Once the practice faxes, e-mails, or electronically exports delinquent account information, FMS Financial mails two letters to the patient within the next month, giving the patient 30 days to dispute the account as required by the FDCPA and warning that the account will be sent to a credit reporting bureau.

"This is one of the major differences between a collection agency and a practice," Hausfeld says. "Practices can't pull credit on anyone and they can't report people to credit agencies. That's a tool that we leverage significantly to get people to pay us."

If patients respond to the letters, the practice pays a flat fee—\$30 at Hausfeld's firm—regardless of the balance. Depending on the terms of your agreement with a collection agency, these accounts may automatically go to the agency's collection floor at its regular rate if the patient does not respond within a few weeks.

Whatever solution you choose, tough economic times dictate that you examine every option to optimize your collections. "Physicians need to focus on their core competency, and that core competency is to provide excellent medical care," Hausfeld says. "The administrator is the key person in the practice who monitors the flow of debt and the liquidation of that debt. You have to examine the revenue cycle with an eye to maximizing the amount of money the practice takes in." ■

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Prepare your organization to comply with Red Flags regs

When Congress passed the Fair and Accurate Credit Transactions Act of 2003 (FACTA), little did healthcare organizations suspect that they would be on the hook for yet another government mandate. But that's exactly what's happened, and the May 1 deadline for implementing procedures to comply with the regulations, known as the Identity Theft Red Flags rule (16 *CFR* 681.2), is fast approaching.

Section 114 of FACTA required six regulatory agencies to create rules mandating organizations that deal with consumer information to monitor for identity fraud, says **Robin J. Fisk, Esq.**, principal of Fisk Law Office in Ashland, NH. Since the agencies primarily regulate the financial industry, healthcare organizations were slow to discover that the rules might apply to them.

The Red Flags regulations define a pattern, practice, or specific activity that could indicate identity theft. In addition to financial institutions, they apply to creditors, defined as "any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal, or continuation of credit; or an assignee of an original creditor who participates in the decision to extend, renew, or continue credit."

Typical creditors include consumer organizations such as banks, auto dealers, and utility and cell phone companies. However, the Federal Trade Commission (FTC) has interpreted the regs to apply to other organizations, including nonprofits and government agencies, Fisk says. Although the FTC usually has no jurisdiction over nonprofits, the agency has taken the position that it holds jurisdiction when a nonprofit performs functions that are similar to a for-profit. "Any person that provides a product or service for which the consumer pays after delivery is a creditor," the FTC's enforcement policy states.

To be subject to the Red Flags regulations, healthcare organizations must also maintain covered accounts, which may include consumer accounts and any other type of account that presents a reasonable risk of identity theft that could harm the patient or provider.

"Merely accepting credit cards as a form of payment is not sufficient to make an entity a creditor," Fisk says. "The continuing credit relationship also must involve either of the two types of covered accounts. But even if a provider can somehow escape the first part of the definition—hard to imagine in this day of increased patient financial responsibility—its receivables may well be considered covered accounts under the second part because there is a reasonably foreseeable risk of medical identity theft to the provider's customers.

"Insurance products are not going in the direction of collecting from patients everything they owe on the spot and not extending credit," she adds. "If anything, they're extending more credit to patients. And although best practices talk about collecting copays and deductibles up front, some insurance products don't allow you to do that, so that's not a practical solution to eliminate the problem."

Develop and implement written policy

Although the Red Flags rule went into effect November 1, 2008, at the 11th hour, the FTC agreed to defer enforcement "as to the entities under its jurisdiction" until May 1 because of "confusion and uncertainty within major industries under the FTC's jurisdiction." (See "Online resources" on p. 8.) Creditors such as physician practices and other healthcare organizations that were subject to the six-month grace period could face civil penalties if they fail to comply with the rule after that date, Fisk says.

To comply, healthcare organizations must develop and implement a written identity theft prevention program designed to detect, prevent, and mitigate identity theft in connection with covered accounts, Fisk says. The prevention program may be scaled to the size and complexity of your organization, as well as the nature and scope of your exposure. However, your program must also consider guidelines regarding the Identity Theft Red Flags that were originally published in the

Federal Register November 9, 2007. (See “Online resources” on p. 8.)

These guidelines, which will be updated periodically, are intended to assist creditors in creating and maintaining a program that satisfies the requirements of the Red Flags regulations. The guidelines cover risk factors for identifying red flags, categories of red flags, and methods for preventing and mitigating identity theft.

Your board of directors, or your senior executive if your organization doesn't have a board, must appoint someone to develop your compliance program, Fisk says. The Red Flags compliance officer's first order of business is to determine whether your organization maintains covered accounts. Next, the compliance officer must conduct a risk assessment of your covered accounts, including the methods you provide to open and access accounts and your organization's previous experiences with identity theft.

Your compliance program must include reasonable policies and procedures to identify red flags for covered accounts and ensure that the program adequately addresses them. The program should instruct staff members on how to respond appropriately to prevent identity theft and to mitigate any effects from identity thefts that occur. The program must also include a process that incorporates updates to keep pace with changes in patient risk and to your organization's programs.

Incorporate vendors into compliance plan

Finally, your organization must implement the program and provide for its continued administration, including training staff members to manage the program, identifying which outside service providers deal with covered accounts, and overseeing these vendors to ensure that they incorporate adequate protections for covered accounts.

“If you bring in an outside vendor to extend credit to patients on your behalf, you're still subject to these rules,” Fisk says.

LRGHealthcare, a healthcare charitable trust in Laconia, NH, that encompasses Lakes Region General

Hospital and Franklin Regional Hospital, has already written a Red Flags compliance program and presented more than three dozen training sessions to its employees, says **Diane L. Blaha, FHFMA**, the organization's compliance officer. Notification to service providers is one of the biggest challenges.

“I had to go back to our security breach policy—who do we notify and who has access to our patient records?” Blaha says. “We have a lot of client relationships in our labs, so we certainly need to notify them. And although we employ many of our professional staff, I need to notify the stand-alone practices about our compliance plan as well.”

Blaha says she has already identified one snag in meeting compliance with the Red Flags regs. LRGHealthcare uses an intermediary to pull credit reports when it places patients on a payment plan. Even if the health system notices an address discrepancy between a patient's information and his or her credit report and suspects identity theft, the credit agency will not accept that information unless it comes from a bank.

“They don't even know how to handle this,” Blaha says, noting that the agency will need to develop an internal process that allows providers to report address discrepancies. “The whole purpose of the Red Flag rules is to act like banks and other financial institutions. Address discrepancies are very much a part of this.”

Consider financial and medical identity theft

The FTC rules seem straightforward enough, Fisk says, but the devil is in the details.

“There's a distinction between identity theft and identity abuse or misuse,” she says. “The Red Flag rules are targeted at financial identity theft, but a bigger issue is identity misuse.” Sometimes, the problem isn't that someone stole a medical ID card and used it, but that someone with health insurance willingly provided a medical ID card for another person to use.

“The current rules written by the FTC deal with identity theft, and whether they apply or not depends on

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whether the practice extends credit,” Fisk says. “That really misses the mark, because if I steal your insurance card, I’m not trying to avoid a copay; I’m trying to access your insurance benefit. So the FTC rules are a crude tool to get at the real issue.”

The FTC is requiring healthcare providers to tailor their guidelines to cover financial and medical identity theft. But with medical identity theft, the mitigation is particularly complex, Fisk says.

“You have to figure out how it occurred and whether improvements can be made to the program,” she says. “Your program should provide guidance on whether and when you continue to provide care after medical identity misuse has been detected. Your program also should provide guidance on when and how to notify the victim—taking into consideration times when you suspect consensual medical ID misuse, not theft—and how you want to coordinate with any law enforcement efforts.”

Whether and when to involve law enforcement is a huge issue for hospitals, Blaha says. Even when emergency room personnel suspect that a patient may be committing identity theft, the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) requires them to conduct medical screenings and provide necessary treatment without disclosing their concerns to the patient.

“We know it’s a felony when someone comes in and uses another person’s name,” Blaha says. “But because of the EMTALA rules, we can’t just turn that patient away.”

Your compliance program should also instruct when to place a billing account on hold and when and how to correct billing and medical records—including information that has been shared with other providers and practitioners. And if protected health information is disclosed, the compliance program must determine whether the disclosure should be addressed under Health Insurance Portability and Accountability Act of 1996 privacy rules. ■

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Online resources

To view the Federal Trade Commission statement delaying the implementation of the Red Flags rule, visit www.ftc.gov/opa/2008/10/redflags.shtm. To read the federal guidance on the Identity Theft Red Flags published in the November 9, 2007, *Federal Register*, go to <http://edocket.access.gpo.gov/2007/pdf/07-5453.pdf>.

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