Sunshine Community Health Center
HC 89 Box 8190, Mile 4.4 Talkeetna Spur Rd, Talkeetna, AK 99676
Willow Clinic: PO Box 1049, 24091 Long Lake Road, Willow, AK 99688
Telephone: 907-733-2273 Fax: 907-733-1735 E-Mail: SCHC@sunshineclinic.org

PATIENT FINANCIAL RESPONSIBILITY

We would like to thank you for choosing Sunshine Community Health Center and allowing us to provide for your healthcare needs. We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding our financial responsibility policy. By signing this document, you agree to the following:

RESPONSIBILITY FOR THE BILL

- I agree that I am financially responsible for all items/services provided to me at the Sunshine Community Health Center.
- I agree that payment for service, including co-pays, is due at the time service is rendered. Payment will be accepted in cash, check, MasterCard or Visa.
- I agree a $30 charge will be applied to checks returned non-sufficient funds.
- I agree that all dental charges resulting will be paid in full prior to completion of work. Initials_____

ACCEPTANCE OF THIRD PARTY COVERAGE

Medicare-Medicaid-Insurance-Workers' Compensation

- The Sunshine Community Health Center will accept "Assignments of Benefits" on verified insurance policies and submit a bill to the carrier on the client's behalf.
- SCHC does not make any assurances or guarantee of any kind that the charges for services I receive will be covered by Medicare, Medicaid or any Third Party Payer.
- Any balance after Third Party coverage is due upon receipt of billing statement. Initials_____

REJECTED CLAIMS

- I agree to pay SCHC for all services that are provided but are not covered by Medicare, Medicaid or other Third Party Payer.
- I agree that it is my responsibility, not Sunshine Community Health Centers, to negotiate for payment of a claim that is disputed by the payer.

Initials_____

PAYMENT ARRANGEMENTS

- Sunshine Community Health Center will make reasonable efforts to assist clients in meeting their financial obligations.
- Payment plans will be entered into at SCHC's discretion
- Payment installments must equal at least twenty percent (20%) of the balance. Initials_____

OUTSTANDING ACCOUNTS

- SCHC reserves the right to request deposits and payment for outstanding balances. Deposits will be based on outstanding balance plus client's share of the new services to be performed.

Initials_____

BAD DEBTS / LEGAL ACTION

- I agree that if my account is not paid in full or satisfactory arrangements made within the allowable time frames, SCHC reserves the right to refer the account to an outside collection agency.
- I agree if my account is sent for collection, I will be required to pay a deposit on the day of service prior to being seen for any future visits.

Initials_____

SPECIAL CIRCUMSTANCES

- In an emergency, services may be provided regardless of the clients account status. Services will be provided for that issue alone.

Initials_____

The Business Office Staff and Management welcome the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms of this form.

_____ _____

Patient Signature Date