CAMAI COMMUNITY HEALTH CENTER

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Payment in full is expected at the time of service unless other written arrangements are made in advance. **Any account one hundred twenty (120) days outstanding is subject to collections.**

PAYMENT OPTIONS: Regardless of which payment option you choose, you are responsible for payment of services you receive from this Community Health Center.

1. **Cash, MasterCard/Visa:** This includes money orders, personal checks, and any credit card payments.
2. **Purchase Orders:** We accept purchase orders from reputable businesses by prior written agreement, *however* if the company doesn't pay you are still responsible. **Purchase Orders are due net 30 days.**
3. **Insurance:** For patients with insurance we will submit to your primary and secondary insurances only. We expect to collect your co-pay at time of service if you only have one insurance. We expect your insurance to pay within thirty (30) days of date billed. If payment is not received within this time frame the amount owed will be transferred to you and due at that time. If you wish to utilize this service, please present your insurance cards before being seen. If your insurance pays directly to you all charges are due at time of service. **YOU MUST PRESENT YOUR INSURANCE CARDS AT EACH VISIT.**
4. **Discounted Services: (1)** We offer a **20%** discount for full payment at time of service. **(2)** You may qualify for the Sliding Scale Discount that we offer to all patients. The amount you are responsible to pay is based on Federal Guidelines for family size and income. You are required to fill out an income declaration that will determine the amount you owe. All other sources of payment will be pursued prior to applying any discounts. **YOU ARE EXPECTED TO PAY ANY AMOUNT OWED BY YOU AT TIME OF SERVICE. Any unpaid amounts are subject to collections.**
5. **Worker's Compensation:** Camai CHC will file **in State** W/C claims on a case by case basis. **Please notify receptionist before services are provided. ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILTY.**

I hereby authorize payment directly to Camai CHC.

Signed: _____ Date: _____

Your signature below is your acknowledgment that you have read and understand and agree to the conditions set forth in this document.

Signed: _____ Date: _____

P.O .BOX 211 • NAKNEK, ALASKA 99633 • Telephone (907) 246-6155 • Fax (907) 246-6158

Camai Community Health Center, Inc.
Discount Application

ALL INFORMATION IS CONFIDENTIAL

Why do we need to know your household income?

- Some of our funding comes from grant monies that require income information from our patients to prove a financial need in the communities we serve.
- These grants allow us to provide a much higher level of care than we could otherwise afford.

Definitions:

Household members:

All members of a household who are related and/or pooling financial resources are counted as one family.

Income:

Income is defined as monies received from all sources before taxes, including:

- Wages and Salaries
- Receipts from self-employment less operating expenses
- Payments from public assistance, social security, strike benefits, military allotments, disability, child support, government or private pensions, regular insurance or annuity payments
- Income from dividends (including permanent fund & longevity dividends), interest, rents, royalties, estates or trusts

Eligibility Determination

Household members/ Household income:

List your name and the name(s) of **ALL** individuals who live with you.

Name:	Relationship:	Annual Income
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL # IN HOUSEHOLD: _____ TOTAL HOUSEHOLD INCOME:_____

***This information must be updated each year, and anytime your income, household size and/or medical insurance status changes. This is a self declaration of income. Camai Community Health Center, Inc., may request additional income information such as last year's w-2, tax return or a pay stub.**

****I understand that the information I provided on this form is subject to verification by Camai Community Health Center, Inc. and/or federal agencies. I authorize the community health center to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. I certify that the above information is true and correct to the best of my knowledge.**

☐ **I CHOOSE NOT TO PROVIDE THE ABOVE INFORMATION WITH THE COMPLETE UNDERSTANDING THAT I AM RESPONSIBLE FOR FULL CHARGES**

_____ _____
Patient/Guardian Signature Date Printed Name

_____ _____
Signature of Health Center Representative Date Discount % to be applied

Patient Chart # _____