Health Ministries Clinic
COMMUNITY HEALTH CENTER

PAYMENT AGREEMENT

I agree all payments and co-payments must be paid at the time of service. I understand in order to be eligible for the sliding fee scale I must provide proof of income. Proof may consist of my previous tax return, paycheck stubs (3), unemployment printout, etc. This information must be provided at the time of visit for the sliding scale to be offered. I understand if my account is 90 days past due, I will receive a letter stating I have to pay on my account or I am subject for my past due account being written off to bad debt. I understand partial payments will be accepted unless otherwise negotiated.

INSURANCE FILING

I hereby authorize Health Ministries Clinic, Inc. to furnish information to insurance carriers concerning my illness and treatments. I understand my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to Health Ministries Clinic, Inc. I understand failure to provide HMC with current, accurate insurance information will result in all charges becoming my responsibility or responsible party. All co-pays and co-insurance fees are due at time of service. These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. I understand I will be responsible for any charges not paid by my insurance.

MEDICARE PATIENTS

Patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. I authorize Medicare benefits be made either to me or on my behalf to Health Ministries Clinic, Inc. for any services furnished me by Health Ministries Clinic, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ATTENDANCE AGREEMENT

I agree to contact HMC via phone, website or patient portal prior to the event that I need to cancel or reschedule my appointment. I understand all appointments (i.e., medical, dental and behavioral health) are considered a no show if I fail to report to the clinic for a scheduled appointment. A no show will be implemented when a patient shows for their appointment 15 minutes or more after appointment. I understand I need to arrive 15 minutes prior to my appointment time, to complete the required check-in process and pay fees at the reception desk. I agree if I have two (2) no-shows within a one-year period, I will be required to meet with a Patient Care Coordinator and/or designee prior to scheduling another appointment. I understand if I have a third (3) no-show in a one-year period, I may be informed I will no longer have the ability to schedule future appointments or possibly be placed on “same day scheduling” for a minimum of six (6) months. I understand If I have scheduling privileges suspended I may request that my status be reviewed by the Executive Director. I acknowledge I understand the expectations about the need to keep my scheduled appointment and the potential consequences if this fails to happen.