

## Alcona Health Centers Registration form and Financial Policies

1. Unless advanced arrangements have been made, payment is expected at the time of service. Payment may be made by cash, check, money order, VISA, Discover, or Master Card. **Insufficient Funds Checks:** A fee will be charged to the issuer for all checks returned for insufficient funds. This fee will be set periodically by the AHC Board of Directors.
2. We offer a reduced (Sliding) Fee program for those who qualify. Please inquire if further information is needed. No one will be refused services based on the ability to pay. Ability to pay is determined by the Federal Poverty Guidelines which are published annually.
3. If arrangements have been made to pay installments, and the terms of the agreement are not met, collection procedures may be initiated according to the Alcona Health Center's policy. All unpaid balances are subject to Alcona Health Center's collections policies.
4. The adult/guardian present with a minor child at the time of service will be held responsible for full payment of services rendered to the said minor child.
5. We accept payments from Medicare, Medicare Advantage Plans, Medicaid and all Medicaid qualified health plans, Blue Cross and Blue Shield, Federal Blue Cross, Blue Care Network, Priority Health, McLaren, Aetna/Cofinity, Humana, Tricare, United Health Care, Allied Benefit Systems, First Health Network, Coventry, Assurant, and Consumer Mutual of Michigan. All insurance information must be provided to the Health Center within 30 days from the date of service or the charges will become the responsibility of the patient/guardian. Alcona Health Centers reserve the right to add or delete insurance plans from whom payment will be accepted.
6. If we are unable to obtain payment/explanation of benefit from your insurance company within 60 days from the date of billing all charges will become the responsibility of the patient or his/her guardian.
7. «Patient Full Name» request the payment of authorized insurance/lab benefits be made to either me or on my behalf to the Alcona Health Centers and medical/dental labs and their affiliate laboratories for any service furnished me by them. I authorize any holder of medical/dental information about me to release to the Alcona Health Center Financing Administration and its agents, my insurance company, medical/dental labs and their affiliate laboratories any information needed to determine those benefits payable for related services.

### **I have read the above conditions and voluntarily agree to these conditions.**

I understand that under the policies of Alcona Health Center, I may be tested for HIV (the virus responsible for AIDS) or HBV (the virus responsible for Hepatitis B) in the event of specific AHC personnel exposure to my blood or body fluids. I understand that I will receive pre and posttest counseling related to HIV and tests related to HIV and test results. I understand that this information will become part of my medical records. Confidentiality of the information will be maintained with limited disclosure as required by law, of upon my written authorization. I understand that this test may be performed without further expressed consent. This form and signature will become a part of my medical/dental record.

Signature of patient, parent, or guardian: «System Esignature»

Patient Name: «Patient Full Name»

Date: «System Date»

DOB: «Birth Date»