□ Anderson Creek Dental Center
□ Anderson Creek Medical Center
□ Angier Medical Center
□ Benhaven Medical Center
□ Boone Trail Medical Center
□ Mobile Unit (Dental / Medical)

TERMS AND CONDITIONS OF SERVICE

Patient Name: ________________________ DOB: __________________ Chart #: __________

Thank you for choosing us as your health care provider. We are committed to providing you with the finest health care available and courteous helpful staff. This service begins from the time you check in at our reception desk to the final payment of your bill. In order to make this process as smooth as possible for our patients, we have established these terms and conditions of service for First Choice Community Health Centers, Inc. (FCCHC)

Personal Valuables: FCCHC requests that patients refrain from bringing valuables to the health center. FCCHC shall not be liable for the loss of or damage to any money, jewelry, glasses, dentures, fur coats and fur garments or other articles of unusual value.

Financial Agreement: The patient and/or guardian agrees on behalf of himself, or as guardian on behalf of the patient, that in consideration of the services to be rendered to the patient, the patient and/or guardian obligate themselves to pay FCCHC in accordance with the regular fees of FCCHC for medical, dental, and other comprehensive health services rendered. Should an account be referred to an attorney and/or collection agency, the patient and/or guardian agrees to pay reasonable collection fees and/or attorney fees.

Payment of Office Visits: All patients and/or guardians must complete personal data and financial information before seeing the provider. Payment in full for all office visits is expected on the day of a patient's appointment. Applicable co-pays, deductibles, and co-insurances will be collected for all insured patients the day of appointment. FCCHC accepts various methods of payment including CASH, CHECK, MASTERCARD, VISA, and CHECK CARDS.

Sliding Fee Verification: If the patient and/or guardian are applying for sliding fee privileges, the undersigned must bring **acceptable** income verification and identification for **all** persons living in the household. If the patient does not have all applicable information with them at the time of the appointment, they will be responsible for 100% of the bill unless a Self Declaration is made (please refer to Sliding Fee Discount Application). All supporting documentation must be submitted to the medical or dental center within ten (10) business days of the appointment regardless of Self Declaration or be responsible for 100% of all charges. **Sliding fee information must be updated every twelve (12) months.**

Third party payers: If the patient and/or guardian is being represented by an attorney as a result of an accident or injury and is expecting reimbursement from a third party, the patient is still responsible for their bill at the time the services are provided. **No arrangements will be made based on prospective third party payments.**

Insurance: The patient and/or guardian hereby assigns to FCCHC, and authorizes payments directly to it of all insurance benefits otherwise payable to the client and/or guardian, not to exceed the regular fees of FCCHC for the services to the patient. The patient and/or guardian is responsible for all charges which are not paid through assignment of insurance benefits. **It is the responsibility of the patient to check the network status of FCCHC with their insurance carrier including verification of services covered**. Please present all of your insurance cards so that a copy can be made for FCCHC records.

(**Over →**)

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Medicare-Medicaid Certification: The patient and/or guardian certify that the information given in applying for payment under Titles XVII and XIX of the Social Security Act is correct. Release of all records required to act on this request is hereby authorized. The patient and/or guardian hereby request payment of authorized benefits on the patient's behalf. Medicare and Medicaid cards must be presented to be copied by FCCHC at time of appointment.

Billing Procedure: As a courtesy, FCCHC will submit the patient's insurance claim on their behalf. Therefore, it is essential that we have complete and accurate information about the insurance carrier. Please remember that the insurance policy is an agreement between the patient and/or guardian and the insurance company. No insurance company attempts to cover all medical costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge. It is the patient and/or guardian's responsibility to pay any balance not paid or covered by the insurance. If your insurance carrier sends the payment for our services to the patient and/or guardian, please sign over the check to FCCHC or you will be billed for the balance.

Collection Process: Our billing and collection office is available to help you with any questions you may have. You may contact them anytime between 8:30 am and 5:00 pm Monday – Friday at (919) 499-5333. You will receive a monthly statement from our office noting any patient balances and payments made within the last thirty (30) days. Please understand that our services are separate from the hospital, therefore the patient and/or guardian will receive a statement from us as well as from the hospital for services rendered at the hospital. Any outstanding patient balance with no payment or activity within sixty (60) days may result in your account being turned over to a collection agency. We will make every effort to negotiate a payment arrangement with the patient and/or guardian prior to this action taking place. Patients who have a balance of $750 or more may result in the patient not being able to make appointments until the balance is paid or a payment plan is signed and kept current. In the event the patient is not permitted to make appointments, FCCHC will continue to see the patient on a walk-in basis only.

No Show Fee: In the event that the patient does not show up for a scheduled appointment without giving FCCHC at least a 24 hour notice, the patient may be charged a $20 No Show fee. Three (3) or more No Shows in any one year period may result in the patient not being able to make appointments for a specified period. In the event the patient is not permitted to make appointments, FCCHC will continue to see the patient on a walk-in basis only.

Consensus to Treat: I voluntarily consent to Providers and Staff of FCCHC to render any and all treatments and/or procedures as deemed necessary by the Providers and Staff of FCCHC.

Agreement: The PATIENT and/or GUARDIAN/FINANCIAL GUARANTOR certifies that the above information has been provided and is complete and correct: That the patient and/or guardian/financial guarantor has read, accepted, and received a copy of the "Terms and Conditions of Service" attached hereto, and is the patient or is duly authorized on behalf of the patient to execute such an agreement.

Signature: ____ Relationship: __________ Date: _______
*Patient, Guardian, and/or Financial Guarantor

FCCHC Staff Signature: ____ Date: ____________

*If patient is a minor or an incompetent adult, signature must be by (1) spouse, (2) guardian, (3) parent or known representative. Please show relationship and provide legal guardianship papers.

FRONT DESK – Scan into patient's electronic record.