Community Health Centers of Greater Dayton

# Billing Agreement

## Health Insurance:

I am aware that it is my responsibility as the patient to give a copy of my insurance card to Community Health Centers of Greater Dayton at the time of my service.

## Self-Pay (Uninsured or Underinsured):

I am aware that it is my responsibility to complete a Sliding Fee Application and return my proof of income within 30 days of my visit or I will be responsible for 100% of my bill.

## Co-Pay/Nominal Fee:

I am aware that my copay/nominal fee is my responsibility. I may pay with cash, check or credit card.

## Statements:

I am aware that I will only receive two (2) statements and one (1) past due statement (a total of 3 statements) before my account may be sent to an outside collection agency. I am also aware if CHCGD receives returned mail because I have not supplied a correct/updated mailing address, I may be sent to an outside collection agency.

## Payment Arrangements:

I am aware that if there is a balance due I may set the balance up on a "Payment Arrangement" if I am unable to pay in full. I am also aware that if I do not set up the payment plan with CHCGD or I do not make my scheduled payments I may be sent to an outside collection agency.

## Collections:

I am aware that if I am sent to an outside collection agency two (2) times that I may be discharged from the practice and I will no longer be able to receive services at Community Health Centers of Greater Dayton.

_____ _____

Patient/Guarantors Signature Date

_____ _____

Patient Name Patient Date of Birth