



# CHS Healthcare

(Collier Health Services, Inc.)



## Method of Payment (Check all that apply)

**Self-Pay**     **Insurance**     **Medicaid**     **Medicare**     **Other** (please specify: \_\_\_\_\_)

I wish to be considered for sliding fee scale. I have no Health/Dental Insurance coverage of any kind or my Health/Dental Insurance does not recognize CHS HEALTHCARE as a participating provider. I shall authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. In the event I am able to secure Health/Dental insurance coverage, I shall authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I will authorize payment of medical/dental benefits to CHS HEALTHCARE, for any services provided while a patient at CHS HEALTHCARE.

I am currently covered by Health/Dental Insurance. I understand that if I am no longer covered by Health/Dental Insurance I may be considered for sliding fee scale. I authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. I authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

I am currently covered by Medicaid. I understand that if I am no longer considered Medicaid eligible I may apply for sliding fee scale if I have no other Health/Dental Insurance. I authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. I authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

I am currently on Medicare. If I currently do not have secondary coverage to Medicare I wish to be considered for sliding fee scale as a secondary. I authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. I authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

**I do not wish** to be considered for the sliding fee scale. In the event I am able to secure Health/Dental insurance coverage, I shall authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I will authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

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I, \_\_\_\_\_, the guarantor, agree to be personally and fully responsible for the payment of any and all medical services, not covered by a federal, state or commercial benefit program, that are provided by CHS HEALTHCARE (Collier Health Services, Inc.).

I understand that I am personally and fully responsible for the payment of all applicable co-payments and deductible or, if applicable, the payment of the appropriate sliding fee. I understand that all applicable payments are due at the time of services.

I understand that in the event that I am unable to pay at the time of service or in the event of an outstanding balance, I will be required to speak to a financial counselor prior to services being rendered. I further understand that in order to remain a patient(s) in good standing, I may be required to sign a payment agreement.

Interpreted into: \_\_\_\_\_ By: \_\_\_\_\_

Signature of Patient/ Guarantor  
Date

Date

Signature of Witness

Patient ID Label

## PATIENT FINANCIAL RESPONSIBILITY AGREEMENT