SVT Health&Wellness
A branch of Seldovia Village Tribe
Partnering in the Journey!

Billing Information

PERSON RESPONSIBLE FOR PAYMENT ON PATIENT ACCOUNT (if other than patient)			
NAME (First)	(MI)	(Last)	DATE OF BIRTH
MAILING ADDRESS (Address, City, State, Zip)			RELATIONSHIP TO PATIENT (if other than self):
EMAIL ADDRESS OK to email? ☐Yes ☐No	PHONE (Home) Message OK? ☐Yes ☐ No	(Work)	(Cell) Message OK? ☐Yes ☐No

Medical Insurance Information:

PRIMARY INSURANCE or ☐ card provided This Insurance Applies to (Check one): ☐ Cardholder, ☐ Cardholder & Spouse, ☐ Cardholder & Family		
INSURANCE COMPANY	SUBSCRIBER ID/POLICY #	GROUP ID
INSURED'S NAME (if not patient)	INSURED'S SSN (if not patient)	
INSURED/RELATION TO PATIENT (if not patient)	INSURED DATE OF BIRTH (if not patient)	

SECONDARY INSURANCE or ☐ card provided This Insurance Applies to (Check one): ☐ Cardholder, ☐ Cardholder & Spouse, ☐ Cardholder & Family		
INSURANCE COMPANY	SUBSCRIBER ID/POLICY #	GROUP ID
INSURED'S NAME (if not patient)	INSURED'S SSN (if not patient)	
INSURED/RELATION TO PATIENT (if not patient)	INSURED DATE OF BIRTH (if not patient)	

Dental Insurance Information:

PRIMARY INSURANCE or ☐ card provided This Insurance Applies to (Check one): ☐ Cardholder, ☐ Cardholder & Spouse, ☐ Cardholder & Family		
INSURANCE COMPANY	SUBSCRIBER ID/POLICY #	GROUP ID
INSURED'S NAME (if not patient)	INSURED'S SSN (if not patient)	
INSURED/RELATION TO PATIENT (if not patient)	INSURED DATE OF BIRTH (if not patient)	

SECONDARY INSURANCE or ☐ card provided This Insurance Applies to (Check one): ☐ Cardholder, ☐ Cardholder & Spouse, ☐ Cardholder & Family		
INSURANCE COMPANY	SUBSCRIBER ID/POLICY #	GROUP ID
INSURED'S NAME (if not patient)	INSURED'S SSN (if not patient)	
INSURED/RELATION TO PATIENT (if not patient)	INSURED DATE OF BIRTH (if not patient)	

RELEASE, ASSIGNMENT, AND STATEMENT OF RESPONSIBILITY I authorize release of any information necessary to process my insurance claims and assign and request payment directly to SVT Health & Wellness (SVTHW). I understand that I may revoke this consent at any time in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment. Furthermore, I agree, whether I sign as legal guardian, guarantor or as patient, that I hereby individually obligate to pay that account in accordance with the regular rates and terms of SVTHW. Should the account be referred to an attorney or collection agency for collection, I shall pay actual attorney's fees and the collection expense. All delinquent accounts may bear interest at the legal rate.

SIGNATURE **DATE**

~ Please turn over for fee discount information ~

We have many resources available to help you pay for your medical and dental needs, including:

- SVT Health & Wellness (SVTHW) discounts to income-eligible patients.
- Assistance with applying for Medicaid, Denali KidCare or Medicare benefits.
- Coordination with the Veteran's Administration for prior approval of care.
- Assistance with enrolling in the Health Insurance Marketplace.
- Prescription Assistance Program for chronic medical condition medications.
- SVTHW's Compassionate Care for chronic medical condition medications.

Please circle your current monthly household income to determine eligibility for fee discounts:

1. **Household Size:** The total number of people living in your household including yourself, spouse, partner, relatives and all children.

2. **Household income** includes **ALL** money (after tax) from jobs, tips, alimony, child support, public assistance, disability, social security, unemployment, **ALL** Permanent Fund Dividends, and Native Beneficiary Dividends.

Household Size:	Income Less than:	Income Between:	Income Between:	Income Between:	Income More Than:
1	$1,265.00	$1,265.01 - $1,897.50	$1,897.51 - $2,213.75	$2,213.76 - $2,530.00	$2,530.01
2	$1,715.00	$1,715.01 - $2,572.50	$2,572.51 - $3,001.25	$3,001.26 - $3,430.00	$3,430.01
3	$2,165.00	$2,165.01 - $3,247.50	$3,247.51 - $3,788.75	$3,788.76 - $4,330.00	$4,330.01
4	$2,615.00	$2,615.01 - $3,922.50	$3,922.51 - $4,576.25	$4,576.26 - $5,230.00	$5,230.01
5	$3,065.00	$3,065.01 - $4,597.50	$4,597.51 - $5,363.75	$5,363.76 - $6,130.00	$6,130.01
6	$3,515.00	$3,515.01 - $5,272.50	$5,272.51 - $6,151.25	$6,151.26 - $7,030.00	$7,030.01
7	$3,965.00	$3,965.01 - $5,947.50	$5,947.51 - $6,938.75	$6,938.76 - $7,930.00	$7,930.01
8	$4,415.00	$4,415.01 - $6,622.50	$6,622.51 - $7,726.25	$7,726.26 - $8,830.00	$8,830.01
9	$4,865.00	$4,865.01 - $7,297.50	$7,297.51 - $8,513.75	$8,513.76 - $9,730.00	$9,730.01
10	$5,127.00	$5,127.01 - $7,690.50	$7,690.51 - $8,972.25	$8,972.26 - $10,254.00	$10,254.01

You may be asked to verify your income by providing the Patient Assistance Representative with documentation. Please respond to any requests for documentation within thirty (30) days. Failure to respond to a request for documentation may result in the end of your discounts, and any actions taken will affect future billed visits.

The income information provided by me is true to the best of my knowledge and I understand that I may be subject to documentation requests as indicated above.

_____ Signature

____/____/_____ Today's Date

_____ Contact Phone Number

OFFICE USE ONLY: **(2018 SFD Guidelines)**
Billing Information applied to patient #'s: _____