Patient Financial Registration

Please let us know if you have questions filling out this form. We're happy to help!

PATIENT FIRST NAME: PATIENT LAST NAME: TODAY'S DATE:

Annual Income: This is information is not associated with the Sliding Fee Discount. Some of our funding comes from grant monies that require patient income information to provide a financial need in the community. These grants allow us to provide a higher level of care than we could otherwise afford.

*NUMBER OF PEOPLE IN HOUSEHOLD:
A "household" is a group of two or more persons related by birth, marriage, or adoption who live together.

*ESTIMATED HOUSEHOLD INCOME (before tax)
$_____ per ☐ Month ☐ Year (check one)

☐ I decline to provide my financial information.

INSURANCE INFORMATION & STATEMENT OF FINANCIAL RESPONSIBILITY

1. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to SVT Health & Wellness. I understand that SVT Health & Wellness will bill my insurance as a service to me; however, I am ultimately responsible for co-payments, deductible payments, and all charges for services not covered by my insurance plan at the time of service

Please Complete OR PROVIDE CARD - Primary Insurance	**Please Complete OR PROVIDE CARD - Secondary Insurance**
Insurance Company Name:	Insurance Company Name:
ID:	ID:
Group/Policy #:	Group/Policy #:
Subscriber's Name:	Subscriber's Name:
Subscriber's Phone #:	Subscriber's Phone #:
Subscriber's Employer:	Subscriber's Employer:
Subscriber's SS#:	Subscriber's SS#:
Subscriber's Date of Birth:	Subscriber's Date of Birth:

2. I understand that I may revoke this consent at any time in writing to the office.

3. I am being seen for a **work-related injury**:

Insurance Carrier Name:	Claim Number
Address:	Employed at:
City, State, Zip:	Date of Injury:
Phone Number:	Time of Injury:

4. I agree that I am responsible for payment of all products or services rendered to me, or the patient for which I am the guarantor of payment, in accordance with the regular rates and terms of SVT Health & Wellness.

5. I understand that the Health Center will make all reasonable attempts to collect amounts due and failure to adhere to payment agreements or financial responsibility may result in my account being sent to a collections agency or attorney, with applicable fees (including attorney's fees and/or collections expense) assessed. All delinquent accounts may bear interest at the legal rate.

6. Should I qualify for American Indian/Alaskan Native Purchased-Referred Care, I understand that the Indian Health Service (IHS):
   a. is the payer of last resort. All other insurance (Medicare, Medicaid, private insurance) must be billed first.
   b. will NOT pay for office visits/labs/dental/radiology services at another facility (including South Peninsula Hospital) without a referral from a SVT Health & Wellness provider <u>before</u> the services are performed, unless it is a life-or-limb emergency.
   c. requires that I present a copy of my Tribal Enrollment card, copy of my Certificate of Indian Blood/BIA Card, Photo ID (driver's license or passport), and for infants a copy of Birth Certificate (if available).
   d. Requires that I apply for the SVT Health & Wellness Sliding Fee Discount Program annually, regardless if I believe I will not qualify for being over-income.

   <u>For Alaska Native and American Indian patients</u>: Tribally-Sponsored Health Insurance (T-SHIP) may be available at no cost to you. T-SHIP pays the insurance premium cost. Alaska Native and American Indian people also do not have to make any co-payments or deductibles when you are seen or referred by Tribal health facilities. Health insurance can help make more services available for you and all Alaska Native and American Indian people. Health insurance can also help you get medical care when you are traveling or away from Tribal health facilities. Enrollment in the Marketplace does not affect your current IHS benefits. You still get all services at IHS and Tribal hospitals and health clinics throughout Alaska and the United States. For more information, please enquire at the front desk.

7. I have read the above information and have no further questions.

_____ _____

Patient/Guarantor Signature Date Signed

If <u>not</u> signed by Patient:

_____ _____

PRINT Patient or Legal Guardian/Representative's Name Relationship to Patient