HealthLinc
YOUR COMMUNITY HEALTH CENTER®

FINANCIAL AGREEMENT

Date: _____

To the Attention of the Billing Department:

_____ _____
First Name *Last Name*

DOES_____ DOES NOT _____ qualify for nominal fee.

_____% PER ANY AND ALL MEDICAL OFFICE VISITS

_____% PER ANY AND ALL DENTAL VISITS

_____% PER ANY AND ALL BEHAVIORAL HEALTH COUNSELING SESSIONS

_____% PER ANY AND ALL OPTOMETRY VISITS

(Initial) _____ I am aware that extra fees may be charged based on slide level when seen by a provider at a HealthLinc clinic.

NOTE:

- THIS IS NOT INSURANCE.
- PAYMENT IS DUE AT TIME OF SERVICE RENDERED.
- ALL BALANCES DUE IN 30 DAYS.
- Balances due may be paid by mail, phone or in person at your clinic site.
- You must be screened annually for eligibility.

_____ I am choosing not to provide income documentation and understand I will not qualify for a discount.

Additional Notes:

CT scans, MRIs, ultrasounds, echocardiograms, stress tests, surgeries, hospitalizations, ambulance transportation, any procedure performed by a specialist, and ER visits are **NOT** covered by HealthLinc. If you have any questions, please contact the provider before services are provided.

_____ _____
Patient *HealthLinc Staff*