WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

PAYMENT AND INSURANCE INFORMATION (ASSIGNMENT OF BENEFITS)

Person responsible for payment (guarantor)

PATIENT NAME AND DATE OF BIRTH			PATIENT'S RELATIONSHIP TO GUARANTOR ☐ Self (skip this section) ☐ Other – relationship to patient:
GUARANTOR LAST NAME	**FIRST NAME**	**MIDDLE, SUFFIX**	**DATE OF BIRTH**
MAILING ADDRESS ☐ Same as patient	city	state	zip
PHONE ☐ Same as patient	**EMAIL** ☐ Same as patient		

Patient health insurance information

HEALTH INSURANCE TYPE ☐ Private insurance ☐ Medicaid ☐ Medicare ☐ Uninsured (skip this section)	
NAME ON INSURANCE CARD	
HEALTH INSURER	**MEMBER ID**

Financial agreement

I understand and acknowledge that:

- I am financially responsible for paying all costs associated with the healthcare services I receive from White Mountain Community Health Center (White Mountain CHC).
- I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy.
- I am financially responsible for charges not covered by my health insurance, including deductibles and co-payments.
- I may choose to pay privately in full for particular services if I do not wish certain sensitive health information to be disclosed to my third-party payer.
- If I fail to provide White Mountain CHC with accurate and updated insurance information, including a copy of my most recent insurance card, I will be billed for services that may otherwise be covered by insurance.

I authorize White Mountain CHC to share health information about me with my health insurance carrier(s) or other third-party payers responsible for paying for my healthcare, including specially protected information such as mental health, substance abuse, and/or HIV/AIDS information. I agree that the patient named in this form is covered by the insurer(s) that I have shared with White Mountain CHC and that I have received no notice of discontinuation of benefits. I authorize such health insurers or other third-party payers, including Medicare, Medicare and TRICARE, to pay the costs associated with my healthcare directly to White Mountain CHC or its contracted agents.

For minors consenting to healthcare services on their own behalf: I understand that if I use a health insurance policy held by my parent or guardian to pay for services, they will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. **INITIAL HERE: _____**

Please speak with a staff member if you would like to pay for your services in a different way to keep your care confidential.

Patient signature: _____ Today's date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible party signature: _____ Today's date: _____