



Payment for Services

It is the mission of Heritage Health to provide affordable medical, dental and mental health services for the community without regard to a person's ability to pay. Patients will have the opportunity to discuss their payment options at the time of check in at the health center or afterwards with one of our financial consultants.

Insurance:

Heritage Health accepts a wide range of medical and dental insurances. Patients with insurance plan(s) are expected to pay the co-payment amount that has been established by their insurance company at the time of service. Heritage Health will bill a patient's insurance for all services; patients may be responsible for additional expenses not covered by their insurance company. Patients may also be eligible for our sliding fee discount that can be applied to the outstanding balance as long as doing so is not prohibited by our contract with the insurance carrier. We will make every attempt to help patients understand their coverage, charges, and discounts available to them.

Sliding Fee Discount:

All patients are eligible for our sliding fee scale. A sliding fee scale means that fees charged to you for services provided may be discounted based upon household income and family size. These discounts are available to patients based on the guidelines provided annually by the federal government.

To apply and qualify for the sliding fee scale we will need (one) of the following listed below for each applicable member of the household:

- ➔ Paystubs from all employed individuals in the household: Valid within the previous twelve (12) months.
- ➔ Prior Year W-2 tax form: Valid until April 15th of the following tax year (e.g.- 2015 W-2 is valid until April 15, 2017).
- ➔ Prior Year Tax Return: Valid until April 15th of the following tax year (e.g.- 2015 tax return is valid until April 15, 2017).
- ➔ Work Verification Form: Valid Health and Welfare work verification form or current Unemployment/No-Work Verification Form: Valid within 60 days of the issue date.
- ➔ Social Security Benefit Form: Valid within previous 12 months.
- ➔ Medicaid Eligibility: Proof of current Medicaid enrollment via online verification of eligibility.

Please provide these documents at the time of your appointment as we will be unable to apply any discounts without proper documentation. Please refer to the table on the following page for a summary of the nominal fees we provide.

If you find that you are unable to pay for your care we want to help. There are multiple options available to help you. Please contact our billing office if you would like to find out more. You will not be refused care based upon your ability to pay for services.

**Due to the high cost of supplies, patients will be required to pre-pay their portion before being allowed to schedule Dental Restorative Services. All other services are available without the pre-payment requirement. Please let us know if you have any questions.*



Sliding Fee Discount Groups (based on family size and household income)

Family Size	Group 1 100% & Below	Group 2 101% - 133%	Group 3 134% - 150%	Group 4 151% - 175%	Group 5 176% - 200%	Group 6 201% & Above
1	\$0 - \$12,060	\$12,061 - \$16,040	\$16,041 - \$18,090	\$18,091 - \$21,105	\$21,106 - \$24,120	\$24,121 - +
2	\$0 - \$16,240	\$16,241 - \$21,599	\$21,600 - \$24,360	\$24,361 - \$28,420	\$28,421 - \$32,480	\$32,481 - +
3	\$0 - \$20,420	\$20,421 - \$27,159	\$27,160 - \$30,630	\$30,631 - \$35,735	\$35,736 - \$40,840	\$40,841 - +
4	\$0 - \$24,600	\$24,601 - \$32,718	\$32,719 - \$36,900	\$36,901 - \$43,050	\$43,051 - \$49,200	\$49,201 - +
5	\$0 - \$28,780	\$28,781 - \$38,277	\$38,278 - \$43,170	\$43,171 - \$50,365	\$50,366 - \$57,560	\$57,561 - +
6	\$0 - \$32,960	\$32,961 - \$43,837	\$43,838 - \$49,440	\$49,441 - \$57,680	\$57,681 - \$65,920	\$65,921 - +
7	\$0 - \$37,140	\$37,141 - \$49,396	\$49,397 - \$55,710	\$55,711 - \$64,995	\$64,996 - \$74,280	\$74,281 - +
8	\$0 - \$41,320	\$41,321 - \$54,956	\$54,957 - \$61,980	\$61,981 - \$72,310	\$72,311 - \$82,640	\$82,641 - +
9	\$0 - \$45,500	\$45,501 - \$60, 515	\$60,516 - \$68,250	\$68,251 - \$79,625	\$79,626 - \$91,000	\$91,001 - +
10	\$0 - \$49,680	\$49,681 - \$66,074	\$66,075 - \$74,520	\$74,521 - \$86,940	\$86,941 - \$99,360	\$99,361 - +

Nominal Fee Schedule

	Group 1 0 - 100% FPL		Group 2 101% - 133% FPL		Group 3 134% - 150% FPL		Group 4 151% - 175% FPL		Group 5 176% - 200% FPL		Group 6 200% & Above
	Nominal Fee	Supply Cost	Nominal Fee	Supply Cost	Nominal Fee	Supply Cost	Nominal Fee	Supply Cost	Nominal Fee	Supply Cost	Full Fee
Medical & Behavioral Health Office Visits	\$25	NA	\$30	NA	\$40	NA	\$50	NA	\$60	NA	Full Fee
Medical Procedures	\$25	80% Discount	50% Discount		45% Discount		40% Discount		35% Discount		Full Fee
Radiology Services (in-house)	\$15	NA	\$20	NA	\$30	NA	\$40	NA	\$50	NA	Full Fee
Laboratory Services (in-house)	\$0	\$5	\$5	\$5	\$10	\$5	\$15	\$5	\$20	\$5	Full Fee
Medical Supplies	\$0	50% Discount	45% Discount		40% Discount		35% Discount		30% Discount		Full Fee
Shared Medical Appointments	\$2	NA	\$4	NA	\$6	NA	\$8	NA	\$10	NA	Full Fee
Dental Preventative/Emergency Services	For dental fees and discounts please refer to the Heritage Health Dental Fee and Discount Schedule										
Dental Restorative Services											
Dental Products											

Patient Name: _____ DOB: ____/____/____

Spouse or Dependents names (If slide is to be applied to their a accounts):

Number in household: _____ Estimated household annual income: _____

Sliding Fee Discount Group: _____

*By signing this form, I certify that the information I am providing is true and correct. I have been made aware of my financial options and obligations and agree to pay for services according to the guidelines above. I also understand that my information must be updated annually or whenever significant changes occur.

PRINT NAME: _____

SIGNATURE: _____

DATE: ____/____/____ **DOB:** ____/____/____

**If you do not wish to provide proof of income, please see front office staff.*