Financial Policy

Thank you for choosing Hopelight Medical Clinic (HMC) as your health care home. Please understand that payment for services provided to you and your family are part of your patient responsibilities. Collecting our co-pays provides HMC with the needed financial resources to continue providing quality health care to you and your family at an extremely low cost. The following is HMC's Financial Policy which we require that you read and sign prior to treatment.

Sliding Fee Schedule

HMC offers a sliding fee plan to allow patients to receive health care services at an affordable fee. Your fee is determined by the income and size of your family. The sliding fee schedule is based on the United States Department of Health and Human Services Guidelines.

Payment for Services

Payment is required at the time of service for all healthcare services being rendered. HMC does not restrict services based on your ability to pay, but your ability to pay is determined by your sliding fee scale rating. Any patient with a past due balance will be required to consult with HMC's Business Manager to set up a payment plan to pay off the past due amount.

HMC accepts cash, checks or Visa, MasterCard or Discover Card.

Insurance

It is your responsibility to provide HMC with current income, Medicare, and Medicaid information. HMC accepts assignment of benefits; however, we do require that you pay any co-payments when services are being rendered. HMC will apply the sliding fee scale discount every time you visit our office. All co-pays are your responsibility.

Assignment of Benefits

I request payment of Medicaid or Medicare insurance benefits to Hopelight Medical Clinic (HMC). I understand that I am financially responsible for all charges not covered by insurance. I acknowledge responsibility to provide HMC with current patient and insurance information. I hereby authorize the release of any medical information necessary to process all claims. I have read the Financial Policy and I understand and agree with this financial policy.

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Signature of Patient or Responsible Party Date