MHC Healthcare
quality healthcare with a heart

Integrated Services
Self-Pay Agreement Form

Patient Name: _____ Patient DOB: _____ Patient Ticket Number_____

Welcome to Marana Health Center, where our professional staff are committed to providing you with the highest quality medical services.

The following is a statement of our Self-Pay Financial Policy, which we require you to read and sign prior to receiving treatment.

Charges are based on the duration of each session. These charges are prior to any discounts listed below. If unable to pay the estimated charges today, we are requesting a down payment of at least 50%.

I understand, as a self-pay patient, that I have the following options for paying my account for today's provider visit (**please initial the option you are choosing**):

- _____I can pay the estimated charges and receive a 30% discount for today's services.

-Or-

- _____I can pay $_____ (50% minimum required) deposit today and the remaining balance within 30 days and receive a 20% discount.

-Or-

- _____I can pay a minimum of $_____ today and will contact the billing department within three (3) business days at 520-818-3616 to make appropriate payment arrangements.

I fully understand that in the addition to the office visit charges today, there may be additional charges for labs, x-rays, immunizations, tests, etc. I further understand that if there are any additional charges, I will receive a statement with any balance due and agree to pay for all additional charges incurred.

(Please initial if either of the below options apply to you)

- _____ I currently have an application pending with AHCCCS, and understand that if I do not qualify for AHCCCS I will be fully and solely responsible for the total bill.

- _____ I have scheduled an appointment with Marana Health Center's Outreach Program on _____ to review my finances and apply or renew a discount program (Sliding Fee Scale) or Federal assistance (AHCCCS). I understand that if I do not qualify for any of these programs, I will be fully and solely responsible for the total bill.

Authorization and Release

I have read and fully understand the Self-Pay Financial Form as outlined above. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all costs associated with the collections process.
By signing this form, I understand I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility.

_____ _____
Printed Patient or Responsible Party Name MHC Health Center Location/Date of Service

_____ _____
Patient/Responsible Party Signature Date MHC Employee Signature Date