LakeCounty
Health Department and
Community Health Center

INSURANCE AND FINANCIAL AGREEMENT

Initial ☐ I understand my insurance plan is an **out of network** insurance plan. The Lake County Health Department and Community Health Center (LCHD/CHC) is a non-participating provider in my insurance network. The LCHD/CHC, as a courtesy, will bill my insurance company. I acknowledge I will be responsible for any charges not covered by my insurance plan or non-response from my insurance company after 30 days. I may not be eligible for referrals or authorizations. I may apply for a reduced fee for applicable charges if I provide an Explanation of Benefits from my insurance company. If my insurance company sends me the payment, I will pay the LCHD/CHC the amount and any outstanding balance on the account. Non-payment may result in collection efforts.

Initial ☐ I understand my insurance plan is an **in network insurance** plan. The Lake County Health Department and Community Health Center (LCHD/CHC) is a preferred provider in my insurance network. I am responsible for all charges not covered or applied to my deductible, coinsurance or a copayment. I may apply for a reduced fee for applicable charges. If my insurance company sends me the payment, I will pay the LCHD/CHC the amount and any outstanding balance on the account. Non-payment may result in collection efforts.

Initial ☐ I understand that my insurance is a Medicaid/Managed Care Organization (MCO) plan in which the Lake County Health Department and Community Health Center (LCHD/CHC) does not participate. I choose to be seen at LCHD/CHC, I understand that my Medicaid plan coverage is waived today. I will not be eligible for referrals or authorizations for services. I am responsible for all charges incurred. The LCHD/CHC will not bill my insurance company. I may apply for a reduced fee for applicable charges and non-payment may result in collection efforts.

Initial ☐ I understand that my insurance is a Medicaid/Managed Care Organization (MCO) plan in which the Lake County Health Department and Community Health Center (LCHD/CHC) participates. My Primary Care Provider (PCP) is not a LCHD/CHC provider. I understand by not changing my PCP that I will not be eligible for referrals or authorizations for services.

Initial ☐ I understand that Medicaid or my insurance does not cover the following procedures. I will be responsible for the fees and understand that payment is expected at the time of service. I may apply for a reduced fee for applicable charges. Non-payment may result in collection efforts.

Date of Service	Description	Code	Tooth	Surface	Estimated Fee Range

_____ _____

Patient Signature Date Witness Date

_____

Parent/Guardian Signature Date

PATIENT NAME: _____
DOB: _____
MRN: _____
Rev. 5/16