Chiricahua Community Health Centers, Inc.
"Caring for patients, building healthy communities"

Self-pay Financial Notice

(520) 459-3012

Patient Name: _____ Medical Record Number: _____

Date of Service: _____

☐ **I agree to pay the prompt payment incentive fee of $45 at the time of service.** This payment will include a visit with the medical provider and any medical, laboratory or radiology testing that can be completed by CCHCI-owned equipment and by CCHCI staff (i.e. EKG, in-house laboratory, radiology, injections and minor procedures). I also understand prescriptions, non-CCHCI radiology and laboratory orders, and specimens sent to a lab for processing are additional charges and will be owed to the rendering facility.

OR

☐ **I decline to pay the prompt payment incentive fee of $45 at the time of service.** I understand I am responsible for paying a copayment of $20 due today and all fees incurred during today's visit. **I understand that the significant financial benefits of various services associated with the prompt-pay incentive are no longer applicable if I choose this option.** We are unable to determine what services will be rendered prior to your evaluation by the provider. In an effort to provide you with a fee, below are the possible fee ranges we may bill you for.

New Patient	Established Patient	Other Services
CPT Codes / 99203 - 99205 Fee Range / $216.36 - $414.20	CPT Codes / 99213 - 99215 Fee Range / $146.16 - $290.12	See disclaimer

DISCLAIMER: You will incur additional fees for in-house laboratory services, medications (oral and injectable), procedures, and treatments provided during your office visit. **I also understand prescriptions, non-CCHCI radiology and laboratory orders, and specimens sent to a lab for processing are additional charges and will be owed to the rendering facility.**

By signing below, I agree to pay for all fees incurred during my visit today.

Patient / Guarantor Name:	**Relationship to Patient:**
Mailing Address:	**Phone Number:**
Signature:	**Date:**