

FINANCIAL AGREEMENT

Date:		
To the Attention of the Billing I	Department:	
First Name		ast Name
DOES	DOES NOT	qualify for nominal fee.
% PER A	NY AND ALL MEDICAL (OFFICE VISITS
% PER A	NY AND ALL DENTAL V	SITS
% PER A	NY AND ALL BEHAVIOR	AL HEALTH COUNSELING SESSIONS
% PER A	NY AND ALL OPTOMET	RY VISITS
	e that extra fees may be o der at a HealthLinc clinic.	charged based on slide level when seen
ALL BALANCES DUE	TIME OF SERVICE RENIN 30 DAYS. paid by mail, phone or in	
I am choosing not to for a discount.	o provide income docume	entation and understand I will not qualify
Additional Notes:		
transportation, any procedure	performed by a specialist	tests, surgeries, hospitalizations, ambulance, and ER visits are NOT covered by he provider before services are provided.
Patient	 Heal	thLinc Staff

Patient #: _____

Rev. 04/2017

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