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Financial Responsibility Agreement

__, understand that I am responsible for all charges incurred for Ι,_ treatment provided to me at Community Health Connections. I consent that the healthcare benefits from my insurance policy are paid directly to Community Health Connections, in consideration of services rendered up to the total amount of my account.

It is my responsibility to provide the correct insurance information. Any balance remaining after insurance benefits have been paid is my responsibility. I will pay that balance within 60 days unless other arrangements have been made. I also understand that in the event of default, my account will be sent to a collection agency.

Co-Pays are due at the time of services.

I authorize Community Health Connection to release any information acquired in the course of my treatment to my insurance company.

Print Name		DOB:	
Signature		Date:	
(Minor Patients)			
Patient Name			
DOB:			
Parent/Legal Guardiar	1 Name		
Parent/Legal Guardiar	n Signature		
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Date			
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			10/2022
			10/2022
Fitchburg Health Center 326 Nichols Road Fitchburg, MA 01420	Gardner Health Center 175 Connors Street Gardner, MA 01440	Leominster Health Center 14 Manning Ave. & 165 Mill St. Leominster, MA 01453	ACTION Health Center 130 Water Street Fitchburg, MA 01420