South Cove Community Health Center

Credit & Collection Policy, Effective October 1, 2015

South Cove Community Health Center

Credit & Collection Policy, January 1, 2014

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2.0 General Definitions of Emergency Care, Urgent Care, and Medically Necessary Service

2.1 Emergency Care, Not applicable to CHC

2.2 Urgent Care

Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

3.0 General Collection Policies and Procedures

3.1 Standard Collection Policies and Procedures for patients

(a) The health center shall make reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. Such reasonable efforts may include:

The center's members services staff will provide all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provide assistance, as needed, to the patient in completing the form. A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer.

Members' services staff will request each returning patient, at the time of visit, whether there have been any changes in his or her insurance coverage status. If there has been a change, the new information will be recorded in the center's practice management system to reflect the appropriate coverage.

(b) The health center shall undertake the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available: (1) an initial bill to the party responsible for the patient's financial obligations; (2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality; (3) documentation of efforts to locate the patient or the correct address on mail returned as an incorrect address, and (4) sending a final notice by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Low Income Patients are responsible for paying co-payments in accordance with 101 CMR 613.04(6)(b) and deductibles in accordance with 101 CMR 613.04(6)(c).

(d) Low Income Patient Co-Payment Requirements. Low Income Patients are responsible for copayments for pharmacy services.

1. The copayment for pharmacy services is
   - a. $1 for each prescription and refill for each generic drug in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
   - b. $3.65 for each prescription and refill for other generic drugs; and
   - c. $3.65 for each prescription and refill for brand-name drugs.
2. There are no co-payments for services provided to Low Income Patients who are
   - a. under 21 years of age; or
   - b. pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends.
3. There is an annual maximum of $250 per patient on pharmacy co-payments.

3.2 Policies and Procedures for collecting financial information from patients.

(a) Low Income Patient Determination. An individual must complete and submit a MassHealth Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 516.000. Applications will be processed by Office of Medicaid MA-21 system.

(b) Determination Notice. The MassHealth Agency or Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination of Low Income Patient status.

3.3 Emergency Care Classification; elective or scheduled services differentiated

Not applicable.

3.4 Policy for Deposits and Payment Plans

The Health Center's Billing Department shall provide and monitor Deposits and payment plans as described in Section 5 of this policy for qualified patients as described in 101 CMR 613.08(1)(f).

Each payment plan must be authorized by the Billing Manager or other Health Center authorized person.

3.5 Copies of Billing Invoices, Notices of Assistance, and Signs

(a) Billing Invoices. Copies of Billing Invoices and Notices of Assistance can be found in the Section 12 of this policy. Signs will be posted in areas of the center frequented by patients such as patient reception and waiting areas, in the following both English and Chinese, which will advise patients of the availability of Financial Assistance

(b) Notices. The Health Center will provide individual notice of the availability of financial assistance programs, including Medical Hardship, to a patient expected to incur charges, exclusive of personal convenience items or services, which may not be paid in full by third party coverage.

The Health Center will include a notice about Eligible Services to Low Income Patients and programs of public assistance in its initial bill.

The Health Center will include a brief notice about Eligible Services to Low Income Patients in all written Collection Actions. The following language will be used in billing statements sent to low income patients: "If you are unable to pay this bill, please call (phone #). Financial assistance is available."

The Health Center will notify the patient that the Provider offers a payment plan as described in Section 5, if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

All applicants will be provided with written notice of approval for Health Safety Net or denial of Health Safety Net within 30 days of the application.

(c) Signs. The Health Center will post signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the Health Center location at which to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices must be translated into English and Chinese. Signs must notify patients of the availability of financial assistance and of other programs of public assistance.

3.6 Description of Discount or Charity Program for the Uninsured

South Cove Community Health Center offers Sliding Fee Discounts to patients who are ineligible for the Health Safety Net. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 200% of the FPIG(Nominal Charges may apply). The health center also offers Same Day Payment Discounts to all Patients.

3.7 Hospital Deductible Payment Option

Not Applicable.

3.8 CHC charge of 20% Deductible per Visit to All Partial HSN Patients

(a) Community Health Centers must charge HSN-Partial Low Income Patients 20% of the Health Safety Net payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets his or her Deductible. Hospital Licensed Health Centers, Satellite Clinics, and school-based health centers that provide Eligible Services may either charge the patient the full amount of the service, or charge the patient 20% of the Health Safety Net payment for each visit. The Provider may submit a claim for the remaining balance of each eligible service.

(b) If a Hospital Licensed Health Center, Satellite Clinic, or school-based health center that provides Eligible Services chooses to bill any HSN Partial patient 20% of the payment amount, it must offer this option to all HSN Partial Low Income Patients receiving Eligible Services at the location.

(c) The HSNO may require a Community Health Center to report when a patient's deductible has been met or any other information regarding the patient's deductible in a manner specified by the HSNO.

3.9 Full Versus 20% Deductible.
Not Applicable.

3.10 Offer of 20% Deductible.
Not Applicable to CHC.

3.11 Waive of Collection of Charges.
The Health Center may waive collection of charges from a patient which may include all or part of a payment or copayment. All of the following conditions must be met for charges to be waived:

- after applying for assistance, the patient is determined to be responsible for payment, or the patient is unable to provide the necessary documentation to apply for assistance due to special circumstances
- it is determined that payment would adversely affect the patient's health or socioeconomic status
- the Executive Director, Chief Operating Officer, or Controller approves the waive of collection of the charges

The waive of collection of charges from the patient must be done on a per visit basis only.

4.0 Collection of Financial Information

4.1 Inpatient, Emergency, Outpatient, and CHC Services
The Health Center shall make reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or Guarantor.

4.2 Inpatient Verification
Not applicable.

4.3 Outpatient/CHC Financial Verification
(a) The Health Center shall make reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:

(b) Verification of Income.

1. Verification of gross monthly-earned income is mandatory and shall include, but not be limited to, the following:
    a. Two recent pay stubs;
    b. A signed statement from the employer; or
    c. The most recent U.S. tax return.

2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:

a. A copy of a recent check or pay stub showing gross income from the source;

b. A statement from the income source, where matching is not available;

c. The most recent U.S. Tax Return.

3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

4. The Division's Application for Health Safety Net Confidential Services may be used for the following special application types.

a. Confidential Services. Minors receiving Confidential Services may apply to be determined a Low Income Patient using their own income information and using the Division's Application for Health Safety Net Confidential Services. If a minor is determined to be a Low Income Patient, the Provider may submit claims for Confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. Providers may submit claims for Eligible Services rendered to these individuals for Confidential Services only.

b. An individual who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information if he or she seeks medically necessary Eligible Services. An individual seeking these services is not required to report his or her primary address.

5.0 Deposits and Payment Plans

5.1 Deposits Requirement for Emergency Services and Low Income Patients

Not Applicable.

5.2 Deposits Requirement for Partial-HSN Low Income Patients

The Health Center does not require a deposit from individuals determined to be a Low Income Patient.

5.3 Deposits Requirement for Medical Hardship Patients

The Health Center does not require a deposit from patients eligible for Medical Hardship.

5.4 Payment Plan on Balance Less than $1000

The Health Center will offer an individual with a balance of $1,000 or less a one year interest-free payment plan with a minimum monthly payment of $25.

5.5 Payment Plan on Balance Greater than $1000

A patient that has a balance of more than $1,000.00 will be offered at least a two year interest-free payment plan.

6.0 Populations Exempt from Collection Action

6.1 MassHealth and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) enrollees

The Health Center shall not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, participants in the Healthy Start program, except that the Provider may bill patients for any required co-payments and deductibles. The Health Center may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Health Center shall cease its collection activities.

6.2 Participants in CMSP with Modified Adjusted Gross Income (MAGI) equal to or less than 400% FPL

Participants in the Children's Medical Security Plan whose Modified Adjusted Gross Income is equal to or less than 400% of the FPL are also exempt from Collection Action. The Health Center may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Health Center shall cease all collection activities.

6.3 Low Income Patients – Full HSN

Low Income Patients are exempt from Collection Action for any Eligible services rendered by the Health Center receiving payments from the Health Safety Net Office for services received during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Health Center may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

6.4 Low Income Patients Healthy Safety Net Partial HSN

Low Income Patients with Income between 201 to 400% of the FPL are exempt from Collection Action for the portion of his or her Provider bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 101 CMR 613.06(6)(c). The Health Center may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

6.5 Low Income Patient Consent on Billing for Non-Eligible Services and Exclusions

The Health Center may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed to be responsible, with the exception of services stated in 6.6 and 6.7 of this policy. The Health Center must obtain the patient's written consent to be billed for the service.

6.6 Low Income Patient Consent Exclusion for Medical Errors including Serious Reportable Events (SREs)

The health center may not bill Low Income Patients for claims related to medical errors including those described in Section 10(SRE).

6.7 Low Income Patient Consent Exclusion for Administrative or Billing Errors

The health center may not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error.

6.8 Low Income Patient CommonHealth Deductible Billing

At the request of the Patient, the health center may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth One-Time Deductible as described in 130 CMR 506.009.

6.9 Medical Hardship Patient and Emergency Bad Debt Eligible for Medical Hardship

The Health Center may not undertake a Collection Action against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution.

6.10 Timely Submission of Medical Hardship Application

The Health Center must assist the applicant to complete the Medical Hardship application and assemble the required documentation. Once the applicant has completed the application and assembled all of the required documentation, the Health Center must submit the completed application to the Health Safety Net office within five business days. If the Health Center fails to submit the completed application to the Health Safety Net Office within that time frame, the Health Center may not undertake a Collection Action against the applicant with respect to any bills that would have been eligible for Medical Hardship payment had the application been submitted and approved.

7.0 Minimum Collection Action on CHC Bad Debt

The Health Center will make the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications.
The minimum requirements before writing off an account to the Health Safety Net include:

7.1 An initial bill to the party responsible for the patient's personal financial obligations

7.2 Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation

7.3 Documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable"

7.4 Sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"

7.5 Documentation of continuous Collection Action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous Collection Action, the Health Safety Net Office may use a gap in Collection Action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether a Provider has made a reasonable effort to meet the standard.

7.6 If, after reasonable attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the Health Safety Net Office.

7.7 The patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

7.8 ERBD claim EVS check

Not Applicable.

7.9 HLHC Bad Debt Claim and EVS Check

Not Applicable

7.10 CHC Bad Debt claim and EVS check

The Health Center may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to

1. An uninsured individual who is not a Low Income Patient. The Provider may not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The Provider may not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or
2. An uninsured individual whom the Provider assists in completing a MassHealth application and is determined or determined into a category exempt from collection action in accordance with 101 CMR 613.08(3). Bad Debt claims for these individuals are exempt from the requirements of 101 CMR 613.06(4)(d).

(b) The Health Center provided Urgent Services as defined in 101 CMR 613.02 to the patient. The Health Center may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.

(c) The responsible physician determined that the patient required Urgent Services. A Provider may submit a claim for Urgent Services, but not for other services provided to patients determined not to require Urgent Services.

(d) The Health Center undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(e) The bill remains unpaid after a period of 120 days.

8.0 Available Third Party Resources

8.1 Diligent efforts to identify and obtain payment from all liable parties

The health center will make every effort to identify and obtain payment from all other liable parties, including insurers. Diligent efforts include, but are not limited to:

8.2 Determining the existence of insurance that could pay for medical expenses by asking the patient if he or she has other insurance and by using insurance databases available to the provider. In the event of a motor vehicle accident, this includes investigating whether the patient, driver, and/or owner of any motor vehicle involved had a motor vehicle liability policy;

8.3 Verifying the patient's other health insurance coverage, currently known to the Health Safety Net, through EVS , or any other health insurance resource available to the provider, on each date of service and at the time of billing;

8.4 Submitting claims to all insurers with the insurer's designated service code for the service provided;

8.5 Complying with the insurer's billing and authorization requirements;

8.6 Appealing a denied claim when the service is payable in whole or in part by an insurer; and

8.7 Immediately returning any payment received from the Division when any available third-party resource has been identified.

9.0 Serious Reportable Events

The Health Safety Net does not pay for services directly related to a Serious Reportable Event(SRE) as defined in 105 CMR 130.332 (A).

9.1 Billing and collection of services provided as a result of SRE

The health center shall not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services provided as a result of a SRE occurring on premises covered by a provider's license, if the provider determines that the SRE was:

(a) Preventable;
(b) Within the provider's control; and
(c) Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c).

9.2 Billing and collection for services that cause or remedy SRE

The health center shall not charge, bill, or otherwise seek payment from the HSNO, a patient, or any other payer as required by 105 CMR 120.332 for services directly related to:

(a) The occurrence of the SRE;

(b) The correction or remediation of the event; or

(c) Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis.

9.3 Billing and collection by provider not associated with SRE for SRE-related services

The health center may submit a claim for services it provides that result from an SRE that did not occur on its premises only if the health center and the facility responsible for the SRE do not have common ownership or a common corporate parent.

9.4 Billing and collection for readmission or follow-up on SRE associated with provider

Follow-up Care provided by the health center or a provider owned by the same parent of the health center are not billable if the services are associated with the SRE as described above.

10.0 Health Center Responsibilities

10.1 Non-discrimination

The Health Center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

10.2 Board approval for legal execution against patient home or motor vehicle

The Health Center shall not seek legal execution against the personal residence or motor vehicle of a Low Income Patient determined pursuant to d 613.04 without the express approval of the Provider's Board of Trustees. All approvals by the Board must be made on an individual case basis.

10.3 The Health Center must advise patients of the responsibilities described below in all cases where the patient interacts with registration personnel.

(a) Patient who receives Eligible Services must:
1. Provide all required documentation;
2. Inform MassHealth of any changes in Family Income or insurance status; including but not limited to, income, inheritances, gifts, distributions from trusts, the availability of health insurance and third-party liability. The Patient may, in the alternative, provide such notice to the Provider that determined the patient's eligibility status; and
3. Track the patient Deductible and provide documentation to the Provider that the Deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider; and

4. Inform the Health Safety Net Office or MassHealth when the patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim. The patient must:

a. file a claim for compensation, if available; and

b. agree to comply with all requirements of M.G.L. c. 118G, including but not limited to:

(1) assigning to the Division the right to recover an amount equal to the Health Safety Net payment provided from the proceeds of any claim or other proceeding against a third party;

(2) providing information about the claim or any other proceeding, and fully cooperating with the Division or its contractor, unless the Division determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the patient;

(3) notifying the Health Safety Net Office or MassHealth in writing within 10 days of filing any claim, civil action, or other proceeding; and

(4) repaying the Health Safety Net from the money received from a third party for all Health Safety Net eligible services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, only Health Safety Net payment provided as a result of the accident or other incident will be repaid.

11.0 Patient Rights and Responsibilities

The Health Center must advise patients of the right to:

11.1 Apply for MassHealth, Health Connector Programs, Health Safety Net determination, and Medical Hardship; and

11.2 A payment plan, as described in 101 CMR 613.08(1)(f), if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

The Health Center must advise patients on duty to:

11.3 Provide all required documentation;

11.4 Inform MassHealth or the Provider that determined the patient's eligibility status of any changes in Family Income or insurance status; and

11.5 Track the patient Deductible and provide documentation to the Provider that the Deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider.

11.6 Inform Division/Masshealth of any TPL claim/lawsuit.

11.7 File TPL claim on accident, injury or loss.

11.8 Assigning right to recover HSN payments from TPL claim proceeds.

11.9 Provide TPL claim or proceeding information.

11.10 Notify Division/Masshealth within 10 days of filing TPL claim/lawsuit.

11.11 Repay HSN for applicable services from TPL proceeds.

11.12 HSN limit on recovery of TPL claim proceeds.

12.0 Signs

12.1 Location of Signs

The Health Center will post signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the health center location at which to apply for such programs.

12.2 Size of Signs

Signs must be large enough to be clearly visible and legible by patients visiting these areas.

12.3 Multilingual Signs

All signs and notices must be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the Provider's service area. Signs will be posted in English and Chinese.

12.4 Wording of Signs

Signs must notify patients of the availability of financial assistance and of other programs of public assistance. Copies of Signs can be found in the Section 12 of this Policy.

13.0 Sample Documents and Notices on Availability of Assistance

13.1 Assistance Notice (non-billing invoice)

See Appendix A-1

13.2 Assistance Program Notice in Initial Bill (billing invoice)

See Appendix A-2

13.3 Assistance Notice in Collection Actions (billing invoice)

See Appendix A-3

13.4 Payment Plan Notice to Low Income or Medical Hardship Patients

See Appendix A-4

13.5 Posted Signs

See Appendix A-5

Approved by the Board of Directors of

CHC Name: South Cove Community Health Center

Date: 10/29/15

Authorized Signature: - NELSON K. LIU

Title: BOARD PRESIDENT

No one will be denied care due to lack of ability to pay for services.

Financial Assistance is available through this institution.

The Health Center offers payment plans to Low Income Patients and Medical Hardship Patients.

Same Day Payment Discounts are also available.

Please contact our Social Service Department for Assistance.

你不會因沒有能力支付醫療費用而遭拒絕，請查詢經濟援助計劃。

South Cove Community Health Center
145 South Street
BOSTON, MA 02111 (617)482-7555

1/15/2006

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$240.00

$0.00

$240.00

130091

If you are unable to pay you may be eligible for Financial Assistance. If you have questions, please call 617-521-6786 for assistance.

Test, Patient
Test Address
Test Address, MA 02111

Page: 1

** - Indicates charges for which Addressee is not responsible.

12/30/2005	KANG DI	Office/Outpatient Preventive Visit, Established 40-64yrs	223.00	223.00
12/30/2005	KANG DI	FECES SCREENING FOR OCCULT BLOOD	17.00	17.00

SAMPLE
Initial Bill

January 15, 2006	199	$240.00	$0.00	$0.00	$0.00	$0.00	$240.00

130091-South Cove Community Health Center 145 South Street BOSTON, MA 02111 (617)482-7555

South Cove Community Health Center
145 South Street
BOSTON, MA 02111 (617)482-7555

1/15/2006

199

$240.00

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$0.00

$240.00

130091

Test, Patient
Test Address
Test Address, MA 02111

Page: 1

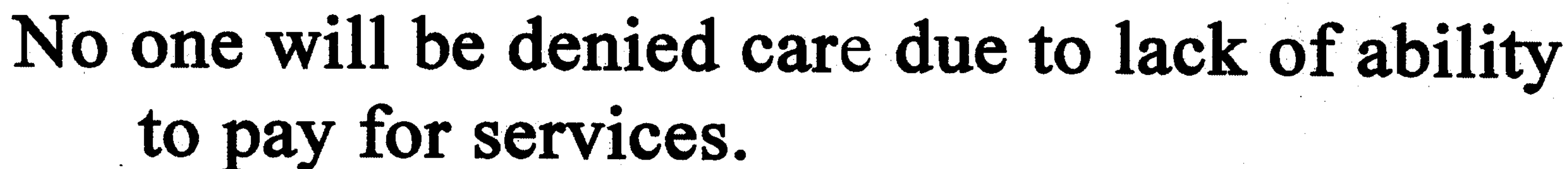
** - Indicates charges for which Addressee is not responsible.

12/30/2005	KANG DI	Office/Outpatient Preventive Visit, Established 40-64yrs	223.00	223.00
12/30/2005	KANG DI	FECES SCREENING FOR OCCULT BLOOD	17.00	17.00

SAMPLE Follup Up Bill/ Collection

January 15, 2006	199	$240.00	$0.00	$0.00	$0.00	$0.00	$240.00

130091-South Cove Community Health Center 145 South Street BOSTON, MA 02111 (617)482-7555



No one will be denied care due to lack of ability to pay for services.

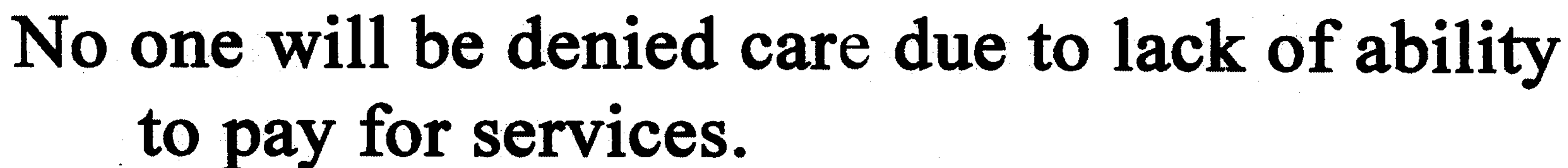
Financial Assistance is available through this institution.

The Health Center offers payment plans to Low Income Patients and Medical Hardship Patients.

Same Day Payment Discounts are also available.

Please contact our Social Service Department for Assistance.

你不會因沒有能力支付醫療費用而遭拒絕，請查詢經濟援助計劃。



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