RAPID CITY HEALTH PROFESSIONALS
Caring solutions for a healthier you!

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SCAN ME

ADVANCED BENEFICIARY NOTICE (ABN)

Check which applies to you:

☐ **Opting out of Medicare**

Medicare Fee-For-Service (FFS) beneficiaries make informed decisions about items and services Medicare usually covers but may not cover in specific situations.

All services, therapies or charges will not be covered by Medicare at Rapid City Health Professionals LLC (RCHP) as we are not contracted care providers. To offer you these services, we must make you aware that we will be charging you directly and that you as the patient will be responsible for payment for these services before they are administered. Since these series are not covered by insurance, we will not be able to file a claim.

☐ **No insurance policy – self pay**

Self-pay, non-private, Medicare/Medicaid insurance plans. You will be charged for the visit based on time spent. You are expected to pay prior to your visit. If you arrive without the ability to pay for your appointment you will be rescheduled, and medications may not be refilled until you can arrange for payment for service.

☐ **Private Health Insurance**

For patients with private health insurance RCHP is contracted with Avera, Dakota Care, Health Partners, Sanford, and Wellmark/Blue Cross/Blue Shield. **After 5/1/23** (end of COVID emergency precautions and telemedicine) you may opt to have a phone appointment if your provider deems appropriate. You will be charged self-pay rates. You must pay at the time of the service and an insurance claim will not be filed.

Special circumstance insurance policies do allow forms of telehealth at RCHP past the date of 5/1/23. This has been prearranged and known to the patient and staff at RCHP via an eligibility check. If you wish to have our billers file your claim and it is discounted in any way due to telehealth care, you will be balance billed for the remainder of our usual fees.

This consent remains in effect for three years.

Printed patient or legal representative name_____

Signature:_____

Date:_____

PLEASE REVIEW AND COMPLETE OTHER SIDE

GUARANTEE OF PAYMENT, AUTHORIZATION OR PHI DISCLOSURE, AND

ASSIGNMENT OF PATIENT DUE BALANCES

I understand, and hereby guarantee, that I will pay the patient portion of fees incurred on the day of the appointment and any past balances due. I hereby authorize RCHP to assign any balance due charges, for which I am responsible, to any of its business associates for the purposes of billing and collecting such charges. I further understand that I am responsible for all of RCHP's usual and customary charges not paid by my health plan, except those contractually discounted.

I understand that if I do not pay the balances due within 90 days of services a 3% late charge with incur, and balances may be forwarded to collections. If I am unable to fulfill my agreement to pay for services rendered at RCHP, I may be unable to schedule further appointments at RCHP and may not receive medication refills.

I understand all these authorizations will remain effective for three years after I have stopped being an active patient of RCHP.

Printed patient or legal representative name_____

Signature:_____

Date:_____