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ADVANCED BENEFICIARY NOTICE (ABN)

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Check which applies to you:

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

For all services, therapies, or charges not covered by Medicare at Rapid City Health Professionals, LLC (RCHP), you will be charged directly and are responsible for full payment before services are administered.

☐ No Insurance Policy – Self-Pay
For self-pay patients and/or those with non-contracted insurance plans, charges will be based on time spent with the provider. Payment is required prior to your visit.

- **If you arrive without the ability to pay, your appointment will be rescheduled.**
- **Medication refills may not be provided until payment for services has been arranged.**

☐ 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 allowances), you may request a phone appointment if your provider deems it appropriate. However, you will be charged self-pay rates, and an insurance claim will not be filed. Payment is due at the time of service.**

PLEASE REVIEW AND COMPLETE OTHER SIDE

- **Certain special insurance policies may still allow telehealth visits after 5/1/23. These exceptions are determined through eligibility checks and communicated to both patient and staff.**
- **If you request RCHP to submit a claim for telehealth and it is denied, reduced, or not fully covered, you will be balance billed for the remainder of RCHP's standard fees.**

This consent remains in effect for three (3) years.

Printed patient or legal representative name:

_____

Signature: _____

Date: _____

SERVICE PRICING

- **New Patient Visit: $300**
- **Established Patient Visit: $100**
- **EKG: $50**
- **THC Certification: $100**

MISSED APPOINTMENT FEES

- **New Patient (missed): $100**
- **Follow-up/Established Patient (missed): $50**

****GUARANTEE OF PAYMENT, AUTHORIZATION OF PHI DISCLOSURE,**

AND ASSIGNMENT OF PATIENT DUE BALANCES**

I understand and agree to the following:

- **I will pay all patient-responsible fees on the day of the appointment as well as any outstanding past balances.**
- **I authorize RCHP to assign unpaid balances, for which I am responsible, to business associates for billing and collection purposes.**
- **I am responsible for all of RCHP's usual and customary charges not covered by my health plan, except those contractually discounted.**
- **If I do not pay balances due within 90 days of service, a 3% late charge will be applied, and balances may be forwarded to collections.**
- **If I fail to pay for services, I may not be able to schedule further appointments at RCHP and may not receive medication refills.**
- **These authorizations will remain in effect for three (3) years after I am no longer an active patient at RCHP.**

Printed patient or legal representative name:

_____

Signature: _____

Date: _____

PLEASE REVIEW AND COMPLETE OTHER SIDE