Community Health Center of the Black Hills

PATIENT FINANCIAL POLICY

PAYMENT RESPONSIBILITY POLICY
(Financial Policy)

Payment is expected in full when services are rendered.

The following is our Patient Financial Policy.

Regarding Medicaid and/or Medicare

Please provide us with your current Medicaid and/or Medicare Card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service.

Private Insurance

Please provide us with a copy of your insurance card at each visit. If payment from the insurance company is not received by 120 days, I am responsible for the charges.

All co-pays and deductibles are due at time of service.

Private Pay Patients

Full payment is due at time of service. We accept CASH, CHECK, and VISA/MASTERCARD (credit or debit card). We offer a CHCBH Discount Program if you qualify. Please ask a receptionist for additional information.

All CHCBH Discount Program co-pays are expected at the time of service.

I realize that I am responsible for any and all differences in charges and payments. I understand that I may be eligible for the CHCBH Discount Program but unless I bring in proof of income (within 10 business days of application), I am responsible for the entire bill. I understand that it is my responsibility to inform the staff of the CHCBH of any changes in my income, family status, or insurance status. I understand that it is my responsibility to update financial paper work on a yearly basis. I further understand that providing CHCBH with false information will result in immediate recalculation of the sliding fee scale for those patient fees occurring during the fraudulent periods and all fess will be due and payable immediately.

Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below you acknowledge and accept our Patient Financial Policy.

X_____
Print Name of Patient

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party

Patient/ Patient Family has qualified for the CHCBH Discount Program at level: _____

Patient's visit co-pay will be _____ at each visit.

Please note that this is a minimum payment and patient/patient family is responsible for any remaining balance after the discount has been applied to the services rendered.

You may receive a separate billing statement from an outside medical source for laboratory and/or X-ray services.

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. The ***Patient Rights and Responsibilities*** informs or your rights and responsibilities as a CHCBH patient.

I acknowledge that I have received the *Notice of Privacy Practices* and *Patient Rights and Responsibilities* forms from the Community Health Center of the Black Hills.

_____ _____

Signature *Date*

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient *Print Name*

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1) Please select one of the following from the race listing:

- ☐ Asian
- ☐ Black/African American
- ☐ American Indian/Alaska native
- ☐ White (not Hispanic or Latino)
- ☐ Hispanic or Latino (all races)
- ☐ Refused to Report

2) Please select one of the following from the ethnicity listing:

- ☐ Hispanic
- ☐ Not Hispanic

3) What is the primary language spoken in your household:

- ☐ Spanish
- ☐ English
- ☐ Other _____
- ☐ Refused to Report

4) Do you need an interpreter? Yes _____ No _____

5) Please select marital status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Legally Separated
- ☐ Partner
- ☐ Other
- ☐ Refused to Report

6) Please select from the following that best describes your living situation:

- ☐ Rent/Own
- ☐ Transitional Housing
- ☐ Doubling up
- ☐ Homeless Shelter
- ☐ Other
- ☐ Not Homeless
- ☐ Unknown
- ☐ Refused to Report

7) Are you unable to work because of a physical or mental disability? Yes_____ No _____

8) Are you a veteran the Uniformed Services of the United States? Yes _____ No _____

9) How many family members are there living in your household? _____

10) Please select one of the following that best represents <u>your family's total annual income</u>:

- ☐ $0 – $20,000.00
- ☐ $20,500.00 - $32,000.00
- ☐ $32,500.00 - $44,000.00
- ☐ $44,500.00 - $56,000.00
- ☐ $56,500.00 - $68,000.00
- ☐ $68,500 - $100,000.00
- ☐ Refused to Report

Entered by: _____

Account Number: _____

Chart Number: _____

Date: _____