



Elk Point
Community
Health Clinic
356-3317

Community Health Clinic

HOW CAN WE CONTACT YOU?



Alcester Medical Center

Patient Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-Mail Address: _____

IF WE NEED TO REACH YOU BY TELEPHONE / E-MAIL / MAIL, WHAT DO YOU PREFER?

(check "√" all that apply)

_____ It is okay to call me at home.

_____ It is okay to call me at work...During what hours? _____

_____ It is okay to e-mail me at the e-mail address I've provided above.

_____ It is okay to mail me at the address I've provided.

IF YOU ARE NOT AVAILABLE, MAY WE SPEAK TO ANYONE ELSE?

(check "√" all that apply)

_____ Please do not speak with anyone but me.

_____ I give my permission to speak with;

_____ OR _____

_____ To remind me I am due for a test or appointment

_____ To give details about dates and/or preparations for a test or appointment.

_____ To discuss my test results, condition, and/or medical care.

_____ To discuss billing information.

_____ You may leave a message on my answering machine/voice mail. *

*If you have an answering machine, we will leave a message to call the clinic.

Signed

Date

Signed

Date

Signed

Date



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Billing Information



Alcester Medical Center
a division of the Union County Health Foundation
104 W 2nd, P.O. Box 468, Alcester, South Dakota 57001
Phone: (605) 934-2122 FAX: (605) 934-1705

Community Health Clinic

Alcester Medical Center

Section A

A-1: If different from patient

Responsible Party: _____
Last First Middle Initial Date of Birth (MM-DD-YYYY)

Billing Address: _____
Apt# City State Zip Code

Phone Number: _____ Business Phone: _____

SSN: _____ Employer: _____

A-2: Insured information

Policy Holder: _____ DOB: _____

SSN: _____ Employer: _____

Policy Holder
Address if different: _____
Apt# City State Zip Code

For Office Use: Attach copy of Insurance Card to this information.

***~ A copy of your insurance card is required to file any insurance claims ~
 ~ If we do not have a contract with your insurance carrier, your account will be set up as self-pay ~***

PAYMENT AGREEMENT

I authorize the release of any medical information necessary to process my claims, and I certify the information provided is correct. I acknowledge I am financially responsible for any deductible, co-insurance and co-pay as described in my health benefit policy. I agree to pay for any services not covered by my insurance plan. If the clinic does not participate with my insurance company, I understand I will be responsible for the entire bill. I further agree, in the event of non-payment, to bear the cost of collection and reasonable legal fees, should this be required. A photocopy of this form shall be deemed as valid and effective as the original.

Signed

Date

Signed

Date

Signed

Date



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Reduced Fee Services

(Sliding Fee)



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In order to provide you affordable health care, this clinic offers reduced fee services. Please complete the following.

You may be eligible for reduced charges at our clinic if your income qualifies. If you have no insurance, have private insurance, or you are on Medicare and do or do not have a secondary insurance company, you may qualify!! Please list income of all adult household members.

Person Employed	Company Name / Phone Number	Income Before Taxes <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

OTHER SOURCES OF INCOME

Pension/Retirement \$	Alimony \$	TANF \$
Disability Pay \$	Child Support \$	S.S.I. \$
Unemployment \$	Other \$	Social Security \$

Please complete table for all people in home:

Last Name, First	Birth Date	Does Person Have Health Coverage?	Name of Insurance: Medicaid, Medicare, Blue Cross, CHIP, etc.	Policy / ID Numbers
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

YOU WILL BE CHARGED FULL PRICE FOR THESE SERVICES UNLESS YOU SUBMIT PROOF OF INCOME WITHIN 14 DAYS OF THE DATE YOU SIGNED THIS FORM.

Please initial if refused

PLEASE READ CAREFULLY BEFORE SIGNING

Proof of income is required. By signing below, I agree that the clinic staff may contact each employer of all people working in the home and/or may contact other agencies to confirm the income listed. Within 14 days of, I will give the clinic a copy of all information asked for, for all people in the home to see if I qualify for reduced fees. Upon receipt of requested information, we will go back up to three (3) months and adjust fees associated with clinic fees.

So that the clinic may have a current Billing Form on file, I will be asked to reapply for the program once a year. I will update my application if the people living in my home change, our income changes, or our insurance changes. If I do not send in proof of information or provide correct information, I may not be eligible for reduced fees and could be charged full price for the services provided.

Signed

Date



Community Health Clinic



Alcester Medical Center

PATIENT RESPONSIBILITY FOR PAYMENT OF ACCOUNT

Charges are payable at the time treatment or service is given.

Regardless of your medical insurance coverage, our office relies on you to settle your account. For your convenience, we will accept:

- a payment of your co-pay (the amount your insurance is not expected to pay) or the deductible with insurance.

- OR -

- a minimum of \$20.00 from all patients with or without insurance on sliding fee for each clinic visit.

- OR -

- a minimum of \$50.00 from all patients on self-pay.

Our clinic will submit primary and secondary insurance claims for you, subject to you having given us current information prior to the service being provided. Policy coverage varies by insurance plan, as do the usual, customary and reasonable fees that various insurance plans have established.

Our contractual arrangement is with you, our patient, not your insurance company. Should there be a dispute related to the charge for the service provided, the settlement of that dispute is between you and your insurance company. **The final responsibility for payment of the services provided to you is yours.**

If for any reason your account reaches more than 60 days past due, it becomes subject to our collection policy which may include assessment of late fees, referral to an agency for collection, and/or filing in Small Claims Court.