



HOMETOWN FAMILY HEALTH

104 W Commerce St/PO Box 35 Plankinton, SD 57368

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## Hometown Family Health Financial Policy

Thank you for choosing Hometown Family Health as your health care provider! We are committed to providing you with high quality and compassionate health care. This financial policy was developed to assist you with any questions that may arise with regards to financial issues. We believe that being forthcoming with our patients in regards to financial expectations allows us to concentrate on our mission of providing exceptional care.

1. **Insurance** - We participate in most insurance plans. If you are not insured by a plan that we have a contract with, or you are insured but do not have a copy of a current card, payment is due in full at time of service. We will bill your insurance company once we receive a copy of your current card, but payment will be your responsibility at time of service.
2. **Co-payments** - All copays must be paid at the time of service. Copays that are not paid at the time of service will be billed a \$5.00 administrative fee. This fee and your copay will need to be paid prior to future appointments.
3. **Non-covered services** - It is virtually impossible for us to have knowledge of what services each insurance plan covers. Knowing your insurance benefits is your responsibility. Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.
4. **No show appointments** - For any second no show appointment there will be a \$25.00 fee. This amount will need to be paid prior to any future appointments. A no show appointment is defined as not showing for your scheduled appointment without notice, or arriving 10 minutes or more without prior notice and approval from staff. After 3 no-shows within one year, patient will be placed on a scheduling restriction for a 6-month period.
5. **Statements/Bills** - After 90 days past due, you will receive a pre-collection letter stating you have 10 days to pay your balance. If we do not receive payment, you will then receive a collection letter stating you have 10 days to pay your balance or be turned over to a collection agency. Once an account is turned over to collections, patient will be placed on a scheduling restriction until payment plan has been established to pay on account. Hometown Family Health is not responsible for any disputes regarding your balance due. Any questions or problems need to be addressed directly to your insurance company.
6. **Insufficient Funds/Returned Checks** - Any check that is returned to us will be charged a \$25.00 return check fee. The amount of the returned check and the \$25.00 fee will need to be paid by cash or credit card within 10 days or it will be turned over to a collection agency at which time we will place patient on scheduling restriction until payment plan has been established.
7. **Assignment of Benefits** - I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to Hometown Family Health any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.