HSA
Payment Policies

The Human Service Agency is required by the Department of Human Services to make available reduced fees for families and individuals who are not covered by any third party payer within specified income levels. This applies to families living in the following counties: Roberts, Grant, Codington, Clark, Deuel, and Hamlin.

The cost of service delivery is continually increasing. Please help us in maintaining our current rate structure by doing one of the following:

A. Pay in full **at each appointment** by cash, check or credit card. *For your convenience we accept VISA, MasterCard and Discover.*
B. Pay your third-party co-payment **at the time of each visit.**

Do you have insurance/Medicaid? Yes No

Primary Insurance Coverage :

Company (number): Company Name:	Company Address:
City, State, Zip:	Company Phone:
Client Relationship to Insured:	
Insured ID #:	Group ID #
Plan Name:	Co-Pay Amount:
Pre- Authorization Required:	Prior Authorization Number:
Insured Name: First: Middle: Last:	Insured Employer:
Insured Address: City: State: Zip:	Insured Phone:
Insured Birth Date:	Insured Sex:

Secondary Insurance Coverage :

Company (number): Company Name:	Company Address:
City, State, Zip:	Company Phone:
Client Relationship to Insured:	
Insured ID #:	Group ID #

Plan Name:	Co-Pay Amount:
Pre- Authorization Required:	Prior Authorization Number:
Insured Name: First: Middle: Last:	Insured Employer:
Insured Address: City: State: Zip:	Insured Phone:
Insured Birth Date:	Insured Sex:

By signing below, you acknowledge that you agree to the following statements:

I understand the Human Service Agency personnel will file insurance claims for me; however, the responsibility to confirm coverage or obtain pre-authorization if required is my responsibility, not the responsibility of the Human Service Agency personnel.

I request that payment under the medical insurance program be made to the HUMAN SERVICE AGENCY on any bills for services furnished to me during the effective period of this authorization, and I authorize HUMAN SERVICE AGENCY to release to the Social Security Administration or its intermediaries or any other carriers information needed to process this claim or any Medicare claim. I further permit a copy of this authorization to be used in place of the original.

I understand that failure to pay my account in full each month or make regular agreed upon payments will result in my account being turned over for collection. I also understand that once my account is past due the Human Service Agency has the right to refuse service.

I agree to notify the Human Service Agency of any financial or third party information changes during the course of treatment.

Authorization period: From until revoked/rescinded.
I accept full financial responsibility for services provided by the Human Service Agency.

Signature of Client/Legal Guardian Date

Printed Name/CID Number of Consumer Date