

# Behavioral Health Providers, P.C.



Helping you through life's transitions

## All Information is Required

Apt. Date: \_\_\_\_\_ Apt. Time: \_\_\_\_\_

Therapist: \_\_\_\_\_ Office: \_\_\_\_\_

### Patient Information

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

We will make every effort to preserve your privacy and will not use any type of communication listed below that you do not wish to be contacted through. Please indicate your preference by a yes or no endorsement.

Home Phone : \_\_\_\_\_ ( Y ) ( N )

Do not call: \_\_\_\_\_ OK to leave message: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ ( Y ) ( N )

Do not call: \_\_\_\_\_ OK to leave message: \_\_\_\_\_

Work Phone: \_\_\_\_\_ ( Y ) ( N )

Do not call: \_\_\_\_\_ OK to leave message: \_\_\_\_\_

Email: \_\_\_\_\_ ( Y ) ( N )

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

### Insured/Guarantor

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI \_\_\_\_\_

Relationship to Pt. \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security # \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

Mental Health Insurance Carrier: \_\_\_\_\_

Phone #: \_\_\_\_\_

Co-Pay: \_\_\_\_\_ Deductible: \_\_\_\_\_

Authorization #: \_\_\_\_\_

# Sessions Authorized: \_\_\_\_\_

Limitation on # of Sessions: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

Payor ID: \_\_\_\_\_ DX Code: \_\_\_\_\_

To be filled out  
by Therapist

### Client's Acknowledgement of Responsibility for Payment for Services

I understand that I am responsible for payment for services rendered to me by Behavioral Health Providers, P.C. regardless of whether I am reimbursed for these services by my insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I have obtained preauthorization from my insurance company if it is a requirement to receive benefits.

Signature and Date

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## Financial & Treatment Policy

Thank you for choosing Behavioral Health Providers as your mental health care provider. We are committed to your treatment being successful.

**In order to serve you better, our office requires that you understand and agree to the following:**

**FEES:** We require payment in full at the time of service unless prior arrangements have been made with the business office. We accept cash, checks, MasterCard or Visa. We ask that you provide a valid credit card with your signature below to be billed if co-pays are not paid at time of service and/or if an appointment is missed without 24 hours notice. By signing below, you understand and agree to be responsible for payment of this fee.

**APPOINTMENTS:** We realize that on occasion you will not be able to make a scheduled appointment. You can leave a cancellation message on our voice mail if a staff member is not available. However, please remember that this time has been reserved for you alone, so **a charge of \$60.00\* will be made to you for missed appointments without notification. Cancellations with less than 24 hours advance notice will be subject to a \$50.00\* charge.** Successful on-going therapy requires a commitment on the part of the client. It is important that you keep your appointment if at all possible.

You are responsible for charges not eligible and/or covered by your medical insurance plan. You are responsible for preauthorization from your insurance company.

**COLLECTION POLICY:** The balance on all accounts is due in full within 30 days of the billing date. A \$7.50\* interest charge will be applied to all accounts 60 days or more past due. Past due accounts may be subject to additional charges incurred, including collection agency fees, attorney fees and court costs. There will be a \$25.00\* fee for returned checks.

**TELEPHONE CONSULTATIONS:** Time spent with you on the telephone by your mental health professional other than for appointment information may be charged at a prorated hourly charge.

**CONFIDENTIALITY AND RELEASE OF RECORDS:** All information regarding patients is considered strictly confidential and will not be given out to anyone without your written consent. In the event of request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee of \$30.\*

**PREPARATION OF FORMS AND REPORTS:** These require chart review and often, discussion with the client. There will be a minimum charge of \$25\* up to a maximum of \$150\* per hour.

**INSURANCE BILLING:** We will file your claim as a courtesy to you with your Primary Insurance Carrier. We will not file claims to Secondary Insurance Carriers, Medicare or Public Aid. It remains your responsibility to pay any deductibles, copayments or other amounts your carrier determines as payable by you. If your insurance carrier has not paid for our services after a 60 day period, you will be expected to pay your balance in full, and may collect from your carrier if you desire. It is your responsibility to provide us with updated information if your insurance company changes or your coverage terminates. By signing below, you authorize your clinician to furnish your health insurance company with all information that any insurance company may request concerning treatment for yourself and/or dependents.

**YOUR ROLE IN PROVIDING ACCURATE INFORMATION AND**

**CERTIFICATION/AUTHORIZATION FOR INSURANCE BILLING:** It is your responsibility to pre-certify your initial visit and to know your plan’s limitations, deductibles and exclusions. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for the amount denied by your carrier.

\*Items with asterisks are not reimbursable by insurance.

**Client’s Rights and Consent for Services**

I authorize Behavioral Health Providers P.C. to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. It is my intent that a copy of this authorization carry the same force and effect as the original. I certify that the information provided on this form is correct to the best of my knowledge. I authorize my insurance company to assign benefits to Behavioral Health Providers.

I have read and understand the above policies. I further understand that the information I have furnished is to be used for management purposes and the agency will ensure confidentiality. I may inquire about or object to the methods and/or type of information stored. My rights are protected under the State and Federal Confidentiality laws and any release of information requires my consent except where required and permitted by law, including child abuse and/or neglect and the intent to harm others or myself. I give my consent to the undersigned clinician to provide evaluation, treatment and/or other services that we mutually determine to be appropriate. I am participating voluntarily and I understand the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

\_\_\_\_\_  
Client and/or Guardian Signature

\_\_\_\_\_  
Date

=====

I hereby give consent to charge my credit card, number and expiration date below, for any missed appointments for which I have not cancelled in the designated prior 24-hour period @ \$100 each.

I hereby give consent to charge my credit card for any co-pays that are not rendered at time of service.

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Expiration Date

( ) American Express ( ) Master Card ( ) Visa

\_\_\_\_\_  
Signature of cardholder

\_\_\_\_\_  
Date

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## PHYSICIAN NOTIFICATION OF CLINICAL SERVICES AND CONSENT FOR THE RELEASE OF INFORMATION

Pursuant to Illinois Law PL 86-1434, you are hereby informed that it is desirable that you confer with your primary physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, Behavioral Health Providers, P.C. is required to notify your primary physician that you are seeking or receiving mental health services.

Dear Dr. \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

I, \_\_\_\_\_ am sending this form to notify you that I am currently seeing  
Therapist

your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience.

I, \_\_\_\_\_, \_\_\_\_\_, of \_\_\_\_\_  
Client Name Date of Birth Address

authorize the exchange of information regarding my clinical care needed to coordinate treatment with my primary care physician.

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 90 days after last contact and I may cancel it in writing at any time.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

I do NOT want my physician to be notified or informed of my treatment.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

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## Permission to Provide Mental Health Treatment to a Minor

I hereby grant my permission for my son/daughter, \_\_\_\_\_

to be treated by Behavioral Health Providers. This permission will remain in force until revoked by me.

\_\_\_\_\_

(Parent or Guardian)

\_\_\_\_\_

(Witness)

\_\_\_\_\_

(Date)