Behavioral Health Providers, P.C.

Helping you through life's transitions

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 reimburseable 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.

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Client and/or Guardian Signature Date

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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

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Signature of cardholder Date