

Behavioral Health Providers, P.C.

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Financial and Treatment Policy

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

To serve you better, our office requires that you understand and agree to the following:

FEES: Copays, Coinsurance, or amount not covered by insurance for any reason is due within 30 days of the bill date. We accept online payments through the patient portal, checks, MasterCard or Visa. There will be a *\$25 fee for return checks. Past due accounts may be subject to additional charges incurred, including collection agency fees, attorney fees, and court cost. To ensure you are notified of any balance please make sure you notify us anytime your email or mailing address changes.

APPOINTMENTS: We realize that on occasion you will not be able to make a scheduled appointment. If this is the case, you can leave a cancellation message on our voice mail or email us at bhproviders@gmail.com. However, please remember that this time has been reserved for you alone, so if you need to reschedule or cancel let us know as soon as possible. If you are going to be more than 10 minutes late for your appointment it may need to be rescheduled.

COLLECTION POLICY: The balance on all accounts is due in full within 30 days of the billing date. We will make multiple attempts to contact you before any further action is taken. Any balance past due more than 90 days is subject to being sent to collections unless arrangements have been made. We are more than willing to work with you, so we ask that you let us know if there are any issues.

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.

PREPARATION OF FORMS AND REPORTS: These require chart review and often discussion with the client. Allow 7 to 10 business days for completion and return of any forms or reports.

INSURANCE BILLING: We will file your claim as a courtesy to you with your Primary Insurance Carrier. 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 Behavioral Health Providers to provide 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.**

Payment

I hereby give consent to charge my credit card, number and expiration date below, for the amount that I authorized and only with my permission. I understand that I can add, remove, or change the card on file at any time securely through the patient portal. I agree that if I wish to set up any payment arrangement or monthly payment plan, I will have to do so in writing, including email.

If you would like us to automatically charge the card below for any amount not covered by insurance check off the statement below:

___I hereby give consent to charge my credit card for any co-pays, co-insurance, or deductible that are not covered by my insurance. I understand that a receipt will be emailed to the email address on file for any payment processed.

Credit Card Number

Expiration Date

() Discover () Master Card () Visa

Signature of cardholder

Date

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 to process an insurance claim. It is my intent that a copy of this authorization carries 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 provided 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