Behavioral Health Providers, P.C.

1100 Cougar Trail Cary, IL 60013 | 321 Franklin St. Geneva, IL 60134
Email: bhproviders@gmail.com
* Phone 847-516-2538 * Toll Free 888-291-2538 * Fax 847-516-2510 *
www.bhproviders.com

ALL INFORMATION REQUIRED

Apt. Date:_____ Apt. Time:_____ Therapist:_____
Office:_____

Patient Information **Insured/Guarantor (If not patient.)**

Last Name:_____
LastName:_____
First Name: _____MI_____ First Name:_____MI_____
Age: _____ Birth date: _____Gender: _____ Relationship to Pt._____
Address: _____
Address:_____
_____
_____
Employer: _____ Home Phone:_____
Employer Address: _____ Cell Phone:_____
Work Phone:_____

Contact Method Consent

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
Please indicate your preference by a yes or no endorsement.

Email: _____ (Y) (N)
Cell Phone: _____ (Y) (N)
_____
Do not call: _____ OK to leave message: ____
Home Phone :_____(Y) (N
Do not call: _____ OK to leave message: _____

Birth date: _____Gender: _____
Social Security #_____
Insured's Employer_____
Employer's Address:_____

Insurance Information

Insurance Co:_____
Insurance ID#: _____
Group #:_____
Insurance Phone #:_____
Mental Health Insurance Carrier:_____

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Work Phone: _____(Y) (N) Phone #:_____
Do not call: _____ OK to leave message: _____

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 benefit.

If there are any changes in your insurance coverage you must notify us immediately. Failing to do so can result in delay in insurance processing and/or additional out-of-pocket costs.

_____ _____
Signature Date

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Helping you through life's transitions

We will only use and disclose the following information for health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Please complete the following - All Information is required

PRIMARY CARE PHYSICIAN NOTIFICATPION 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. _____ _____
(Primary Care Physician First Name) (Primary Care Physician Last Name)

Address:			
Phone Number:		Fax Number:	
Email:		Website:	

I, _____ am sending this form to notify you that I am currently
(Therapist)

seeing 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
(Your Name) (Your Date of Birth)

Address:	

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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: _____ Date: _____

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

Signature: _____ Date: _____

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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

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INFORMED CONSENT FOR TELEVISITS

PATIENT NAME: _____

I, the undersigned, agree to participate in video conferenced visits (Televisits) with Behavioral Health Providers, PC. This means that I authorize information related to my health care to be securely electronically transmitted in the form of images and data through an interactive video connection to and from the above-named psychologist and other persons involved in my health care.

Location: I understand that I must conduct such visits from a private setting where I will not be interrupted.

Equipment: I will understand I must be connected to a secure network or connection. I agree to use only my own equipment for Televisits and will not use my employer's computer or network for the visit.

Identification: I understand that I may be asked to supply information to verify my identity prior to the visit proceeding. If other parties are present during the Televisit, they will also be identified and their purpose for attending the meeting will be clarified.

Nature of Televisit: My psychologist/therapist has explained how the Televisit is performed and how it will be used for my treatment. My psychologist/therapist has also explained how the Televisit will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Possible Risks: Risks that have been recognized include, but may not be limited to:

1. It is possible that the technology will fail before or during the Televisit.
2. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images or poor audio) to allow for appropriate decision making by your clinician.
3. Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

Expected Benefits: I understand that some of the potential benefits of a Televisit include, but are not limited to:

1. Improved access to care.
2. More efficient evaluation and management.
3. Reduced travel time and cost.
4. Easier availability.

Discontinuation. I understand that a Televisit can be discontinued at any time, either by me or by my psychologist/therapist. I further understand that I do not have to answer any questions that I feel are inappropriate or whose answer I do not wish persons present to hear, that any refusal to participate in the Televisit will not affect my continued treatment, and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my treatment might be less successful than it otherwise would be, or could fail entirely.

Alternatives. The alternatives to the Televisits have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person visits and that a Televisit does not necessarily eliminate my need to see my psychologist/therapist in person, and I have received no guarantee as to the Televisit's effectiveness.

Follow-Up Care. When, for whatever reason, a Televisit is unable to provide all the necessary clinical information that my psychologist/therapist believes is necessary to properly evaluate me, prior to the conclusion of the Televisit, I will be informed of the need for an in-person evaluation. If I have an adverse reaction to the treatment or in the event of an inability to communicate because of technological or equipment failure, I will be informed of how I can receive follow-up care.

Records. I understand that my Televisit may be recorded and stored electronically as part of my clinical record. I understand that Televisits, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my clinical records in accordance to Illinois law and that copies of records of Televisits are available to me

upon my written request. I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy

Contact Information: I have received a copy of my psychologist/therapist's contact information, including their full name, telephone number, and physical address. I have also been provided with a list of local support services in case of an emergency. I am aware that my psychologist/therapist may contact the proper authorities in case of an emergency. I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation, I am NOT to seek a Televisit. Instead, I will seek care immediately through my own physician, the nearest hospital emergency department, or by calling 911.

Release from Liability. I unconditionally release and discharge Behavioral Health Providers, PC, and their affiliates, agents, employees; and designees from any liability in connection with my participation in remote Televisits

Ethics and Professional Standards: Behavioral Health Providers, PC and its affiliates are licensed clinicians regulated by the State Board of Examiners and is accountable for their work with you. I understand that if I have any concerns about my care, my psychologist/therapist or their supervisor would be happy to discuss them with me. I can contact them using the contact information listed above.

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the videoconference visits (Televisit), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Patient Signature

_____

Guardian Signature (if patient is a minor)

_____

Date_____

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Please complete the following - All Information is required

Permission to Provide Mental Health Treatment to a Minor

I hereby grant my permission for my son/daughter, _____ to
(Name of minor)

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

Signature Parent or Guardian: _____ Date: _____

Signature Witness: _____ Date: _____

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Consent for Release of Information/Exchange of Information

Patient Information

Name:_____ SS#:_____

Address:_____ Birthday:_____

_____

I authorize Behavioral Health Providers, P.C. to release to below information:

___ Any and All records including but not limited to treatment notes, test results, insurance information, payment history, and balances.
___ ONLY treatment notes and test results.
___ ONLY insurance information, payment history, and balances.

I authorize Behavioral Health Providers, P.C. to release the above selected information to:
Name of Person, Doctor, Practice, or Company:

_____

Address of Person, Doctor, Practice, or Company:

_____

_____

Phone number of Person, Doctor, Practice, or Company:

_____

This Request will expire in 1 year unless listed otherwise. List date here_____

_____ _____

Patient Signature Date

_____

Printed Name

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