Behavioral Health and Education Specialists

BHES Behavioral Health Services Financial Policy

Patient Name:_________________________ **Date:**_________________

Welcome to Behavioral Health and Education Specialists (BHES). We thank you for choosing us as your behavioral health care provider. We are committed to providing our patients the best possible care, and need you to understand that payment of your bill is necessary to provide quality care. For this reason, we have adopted the following financial policy which we require you to read, agree to, and sign prior to receiving any behavioral health care services from us.

Payment Responsibility:

I agree to be financially responsible for the full payment of any and all charges and fees associated with this patient's behavioral health services rendered at BHES. As a courtesy, and for your convenience, BHES will bill the patient's insurance carrier(s) when provided with all of the necessary insurance information. You agree to be responsible for paying any and all policy deductibles, co-payments, co-insurances, and uncovered services at the time the service is rendered (unless the patient's insurance carrier requires us to delay collecting such payment(s)). Although we will verify the patient's insurance coverage prior to providing any services, we strongly encourage you to do the same on your own. If BHES does not receive payment from the patient's insurance carrier within 60 days of billing it, you will immediately be responsible for full payment of the patient's account balance from those services.

If you choose not to have BHES bill the patient's insurance carrier for the services we provide, or if the patient does not have insurance coverage, you agree to assume financial responsibility for any and all charges and fees.

Referrals and Pre-Authorizations:

BHES will attempt to obtain written and/or verbal pre-authorization from the patient's insurance company when such authorization is required. However, I understand pre-authorization for required services is ultimately the patient's responsibility and any services rendered without the necessary pre-authorization in place is my financial responsibility. ☐ Initials

Missed Appointments:

Patients are responsible to show up on-time for all scheduled appointments and to cancel any scheduled appointments at least 24 hours in advance. A No Show/Late Cancel fee of $50.00 will be charged for all missed and/or late canceled appointments. This fee is your personal responsibility and is not covered by insurance.

☐ Initials

Returned Check Fee:

A $25.00 fee will be charged for any checks returned to BHES due to nonsufficient funds. ☐ Initials

Out Of Session Prescription Refills:

All prescription refill requests made outside of a scheduled appointment are subject to a $25.00 fee and psychiatrist approval. ☐ Initials

Methods of Payment:

We accept cash, personal checks, American Express, Discover Card, MasterCard, and Visa

Patient Billing:

Accounts with outstanding balances are generally billed monthly. All statement balances are due 30 days from the statement date. If a statement balance is not paid within 30 days of the statement date and you have not contacted BHES regarding the balance, this account balance may be turned over to an independent collection agency. In that case, information that is helpful and/or necessary for collection purposes will be forwarded to the collection agency. Once an account has been turned over to our collection agency, BHES will only provide the patient additional services after the account is paid in full, or an acceptable payment plan is agreed upon; all payments and payment plans must be made directly to the collection agency. All collection costs incurred by BHES shall be added to the original balance due.

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Patient Name:_________________________ **Date:_________________**

Parent/Guardian Financial Agreement

BHES' policy is that in the case of separation or divorce, the financially responsible party signing below agrees to pay for all services rendered to the patient; this includes all deductibles, co-payments, co-insurance and fees. I understand that if another parent and/or legal guardian is legally responsible for payment or partial payment of the rendered services to the patient, that it is fully my responsibility to collect such payment directly from that parent and/or legal guardian.

☐

Out of Network Acknowledgment

I understand that the patient's assigned BHES provider(s) are currently not in-network with the patient's insurance company. I hereby understand and agree that I am personally responsible for all payments related to the patient's rendered services after the insurance claims are processed by the provided insurance company.

☐ Initial

Self-Pay Acknowledgment

I understand that services the patient receives from BHES providers will not be billed through an insurance company, per my or the patient's request. Therefore, I understand and accept that I am personally responsible for the full payment for any services the patients receives from BHES providers. Also, I understand that full payment for rendered services is required prior to the services being provided.

☐ Initial

I, the undersigned, have read, clearly understand and agree to the provisions of this financial policy. I also authorize the release of any behavioral health information needed to process the insurance claims related to the patient's behavioral health services. Further, I request that payments from my insurance company be paid to BHES for the services rendered.

Financially Responsible Party Name:____________________________ Date:________________

Financially Responsible Party Signature:_________________________ Relationship to Patient:____________________