BEHAVIORAL PSYCHOLOGY ASSOCIATES, P.C.
PATIENT INFORMATION AND BILLING FORM

Patient Name: ______________________________ Today's Date: ______/______/______
First Last Middle

Address: ____
Street (Apt#) City State Zip

Date of Birth: ____________________ Age: _______ Sex: _______ Marital Status: ____________

Emergency Contact: ____
Name Relationship Phone Number

If patient is a **child** (under age 18), complete below:

Client lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other ____________________

Name(s) of all legal guardians: ______________________________

Mother's Name: ______________________________ Father's Name: ______________________________

Address: ______________________________ Address: ______________________________
Street Apt# Street Apt#

______________________________ ______________________________
City State Zip City State Zip

School Name: ____ Grade: ______________

School Address: ____

School Phone Number: ____ Teacher: ____________________

Financial Responsible Party: ☐ Patient ☐ Insured Person ☐ Other ____________________

Patient's relationship to the policy holder: ☐ Self ☐ Child ☐ Spouse ☐ Other ______________

Insured Person's Information:

Insured Person/Responsible Party Name ____

Address: ____ Apt #: ______

City: ______________________________ State: ________ Zip Code: ___________

Home Phone: __________________ Work Phone: ________________ Insured Date of Birth: ____/____/____

All statements and office correspondence will be sent to the above address, unless otherwise indicated.

Insurance Company: ______________________________ **Circle:** PPO HMO POS Other

Insured ID#: (include letter prefix) ______________________________

Group#: ____________________ Insurance company phone # (on back of insurance card): ( ) ______________________

Employer of Policy Holder: ____________________________ Insurance Effective Date: ____/____/____

Do you have secondary insurance? ☐ YES ☐ NO

OUR OFFICE DOES NOT BILL TO SECONDARY INSURANCE COMPANIES. THIS IS THE RESPONSIBILITY OF THE PATIENT. WE WILL PROVIDE ALL INFORMATION FOR THE CLIENT TO BILL SECONDARY INSURANCE COMPANY DIRECTLY.

Who referred you for services: ____

Primary Care Physician: ____ Phone Number: ______________________

Behavioral Psychology Associates, P.C.
BILLING AND INSURANCE INFORMATION

Agreement to Pay/Assignment of Benefits

- BPA wants to work cooperatively with you to make sure that claims and statements are paid accurately and efficiently. BPA will contact your insurance company to obtain your benefit information. I understand the benefits provided to BPA are only an Estimate and not a Guarantee of payment by my insurer.
- If the provider I am seeing at BPA is in network with my insurance company, I understand that BPA will submit a claim to my primary insurance company. I understand that BPA does not submit to my secondary insurance carrier. I understand that I am responsible for any co-payment, co-insurance, deductible, and/or balance resulting from services that are not authorized or covered by my policy, and any other balance my insurance company decides is my responsibility. Services that are not covered may include, but are not necessarily limited to: The evaluation of parent and/or teacher rating scales; phone interviews with collateral contacts; psychological testing; evaluation of records for diagnostic purposes or treatment planning; report writing and preparation; and multidisciplinary school conferences.
- Managed Care: Some insurance policies place limits on the number of sessions you can schedule. This is YOUR RESPONSIBILITY to manage. Please contact your insurance company to find out how best to monitor this situation. ANY services provided by BPA that exceed the allowed number of visits, and are not paid for by insurance, will be YOUR RESPONSIBILITY.
- HRA/HSA Accounts: Please let us know if you have an HRA or HSA account linked to your insurance.
- If the provider I am seeing at BPA is not in my insurance network, I understand that I am responsible for payment at the time of service, and that BPA will provide me with the required documentation to file my claims.
- BPA will not charge for routine phone calls to patients, relatives, referral sources, primary care physicians and other health-care professionals. However, BPA reserves the right to charge for extended conversations with collateral contacts, i.e., teachers and other school related personnel, professionals in the community, patients, relatives, and at times, referral sources. I understand that phone calls are not a service covered by my insurance company, and that I am responsible for the payment of these charges.
- I understand my full payment is expected at the time of service including any outstanding balance. Balances exceeding $200.00 may result in the postponement of additional appointments. I understand if I am being treated by a psychiatrist at BPA, and have a balance exceeding $200.00, I will receive one refill until my balance is paid in full. A member of the BPA billing staff will be available to provide assistance with your account. Also, BPA will charge a $35.00 fee for any check returned to our office by my bank.
- Separation or Divorce: I understand that BPA is not responsible for upholding the financial agreements made between parents in divorce situations. I understand the parent who accompanies the child to the appointment is responsible for making the payment at the time of service.
- For patients under the age of 18 years of age and young adults: If I am unable to accompany my child to an appointment, I understand I am still responsible for payment at the time of service. (i.e. send a check with the child; keep a credit card on file at BPA; make a phone payment prior to their appointment that day).
- I understand I may keep a credit card on file with BPA for co-payments &/or outstanding balances by completing the "BPA Credit Card Agreement Form."
- I understand BPA billing staff will assist patients regarding their accounts. A monthly statement will be mailed to my residence.
- I understand that BPA will take all appropriates steps to collect outstanding balances, but may utilize the services of an agency to collect unpaid debt. BPA will add a 35% administrative/collection fee to the outstanding balance. I authorize BPA to release basic financial and demographic information to the collection agency in order to collect payment for services rendered.

Services Agreement/Notice of Privacy Practices Acknowledgement/Policy and Procedure Agreement

- I agree to participate in services as described in the Psychotherapist-Patient Services Agreement.
- I am aware that I may access a copy of the Behavioral Psychology Associates Notice of Privacy Practices from the BPA website: www.behavioralpsych.com.
- I authorize the disclosure of relevant protected health information among members of BPA's professional and support staff as needed to provide treatment services.
- I understand that BPA requires a 24hr notice of a cancellation. The first time I do not keep an appointment or cancel an appointment less than 24 hours prior to my appointment, I will receive a reminder letter about this policy. Anytime thereafter, my account will automatically be charged a $110.00 No Show/Late Cancellation fee. For Group Therapy, the No Show/Late Cancellation fee is $40.00.
- I hereby assign payment of authorized medical benefits from my insurance carrier to Behavioral Psychology Associates, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
- I authorize Behavioral Psychology Associates, P.C. to release any and all medical information to the above named insurance carrier(s) and/or attorney for the purposes of claim administration and evaluation, utilization review and /or financial audit. This includes information related to mental health services such as assessments, history, diagnoses, medication information, treatment plans and progress, dates of service, and psychiatry and progress notes. This authorization will expire one year from the last date of service. I understand that I have the right of access to inspect and obtain a copy of my protected health information. I may revoke this authorization at any time but revocation will not apply to information already released. Failure to authorize the release of this information may result in your insurance carrier(s) denying claims.

For more detailed information about Office Policies, please visit our website: www.behavioralpsych.com.

I have read, understood, and agree to the contents of this document regarding my responsibilities as a patient receiving services from MD/clinicians at Behavioral Psychology Associates.

____
Signature of Patient (age 12 and older)

____
Date

____
Signature of Parent/Guardian (if patient is age 17 or younger)

____
Relationship to Patient

____
Witness Signature

____
Date

Behavioral Psychology Associates, P.C.
Privacy and Confidentiality Agreement

The staff at BPA is very interested in protecting your right to privacy in the therapy setting. We therefore would like some information from you that will better assist us in protecting your privacy.

In the event that our staff needs to contact you regarding appointments, billing, scheduling, insurance or other office/clinical issues, please indicate below how we may contact you.

May we leave a message at home? Y N NA

May we leave a message on your cell? Y N NA

May we leave a message with a spouse? Y N NA

May we leave a message with another adult in the home? Y N NA

May we leave a message with a child? Y N NA

May we call you at work? Y N NA

May we leave a message for you at work? Y N NA

May we e-mail you? (to confirm appts, BPA program news & updates, etc.) Y N NA

If yes, please provide your email address: ____

May we text you? (to confirm appointments only) Y N NA

If yes, please provide phone number: ____

Please list one or more phone numbers where we may contact you.

Primary # ____________________ (C)(H)(W) Name: ____________________ Relationship: _____________

Secondary# __________________(C)(H)(W) Name: ____________________ Relationship: _____________

Additional # _________________(C)(H)(W) Name: ____________________ Relationship: _____________

Is there anything else we should know that would enable us to better protect your privacy? _______________

____

In providing the above information, I hereby authorize BPA to contact me via the methods listed above. I realize that I have the right to alter the above agreement at any time by requesting a new "Privacy and Confidentiality" Form, completing it and returning it to the office staff. I have read this form and/or have had it read to me and explained in language that I can understand.

Signed: ____ Date: __________________________

Patient/Parent/Guardian