☐ **BPA**
☐ **BCA**

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

Date:_____ Home Phone: _____

Patient's Name: _____
Last name First name Middle name

Address: _____
Street Apt. # City State Zip

Email address: _____

Age:_____ Date of Birth:_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If patient is a child, please provide Parent/Guardian names_____

If patient is a **child** (under age 18), complete below for mother/father. If patient is an **adult** (aged 18 or older), complete below for patient and spouse (if applicable).

Patient or Father Employed by _____ Occupation_____

Business Name & Address_____ Business phone_____

Spouse or Mother Employed by _____ Occupation_____

Business Name & Address_____ Business phone_____

If patient is a child, complete below.

School Name_____ Grade_____

School Address_____

School Phone Number_____ Teacher_____

Primary Care Physician_____ Phone Number_____

Who Referred you to us?_____

Emergency Contact:_____
Name Relationship Phone number

BILLING AND INSURANCE INFORMATION

BPA Patients

Please present your insurance card and a photo ID to the receptionist. They will be copied for our records.

BPA patients: Does the patient have Medical Health Insurance? ☐ Yes ☐ No ___

BPA Patients: Insurance Company Information

Primary Insurance Co._____ Group/Policy #_____

Name of Insured_____ ID #_____

Birthdate of Insured_____

BPA and BCA Patients: Services Agreement/Notice of Privacy Practices Acknowledgement

- I agree to participate in services as described in the Psychotherapist-Patient Services Agreement
- I acknowledge that I have been offered a copy of the Behavioral Psychology Associates/Behavioral Care Associates Notice of Privacy Practices

Agreement to Pay (all Patients)/Assignment of Benefits (BPA Patients only)

- **All patients**: I understand that I am responsible for all charges whether or not paid by insurance. I will pay for charges that are not covered by insurance or any other funding source. This includes charges for checks returned due to non-sufficient funds. I understand I am financially responsible to said therapist/provider for charges not covered by my benefit plan. I further agree that in the event of non-payment I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required. I understand that **BPA** will submit claims to my insurance carrier only if the clinician is an in-plan clinician. If I have a secondary insurance, I will be responsible for submitting claims to them myself. I also understand that **BCA** will not submit claims to insurance companies and any submission to an insurance company will be my responsibility.
- **All patients**: It is understood that all charges are due at the time of service.
- **BPA** patients only: 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 an original.
- **BPA** patients only: 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 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.
- **BPA** patients only: Any money received from the above named insurance company over and above my indebtedness will be refunded to me when my debt is paid in full.
- **BPA** patients only: It is also understood that if I have a managed care or other insurance plan, some services may not be authorized for payment under my benefit plan. These services may include, but are not necessarily limited to: the evaluation of parent and/or teacher rating scales, teacher (or other collateral) interviews, psychological testing, evaluation of records for diagnostic purposes or treatment planning, report writing and preparation, multidisciplinary school conferences, and biofeedback.

_____ _____

Signature of patient aged 12 or older Date

_____ _____

If patient is below age 18, signature of parent/guardian Relationship to patient

_____ _____

Witness signature Date

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

The staff at BPA/BCA 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.

1. May we leave a message on your answering machine/voice mail?	Y	N	NA
2. May we leave a message with a spouse?	Y	N	NA
3. May we leave a message with a roommate?	Y	N	NA
4. May we leave a message with a child?	Y	N	NA
5. May we leave a message with a parent?	Y	N	NA
6. May we call you at work?	Y	N	NA
7. May we leave a message for you at work?	Y	N	NA

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

Phone # _____ Location: (circle one) Home Work Cellular Other

Phone # _____ Location: (circle one) Home Work Cellular Other

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/BCA 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.

Date: _____ Signed: _____
Patient/Parent/Guardian