Behavioral Psychology Associates

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 ☐ Parent 1 ☐ Parent 2 ☐ Other _____

Name(s) of all legal guardians: _____

Parent's Name: _____ Parent'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

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 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.**
- 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. I will also be given documentation regarding the No Surprises Act.
- 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, or 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 BPA Provider 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 $125.00 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 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