



## Behavioral Health and Education Specialists

24402 West Lockport Street, Suite 218, Plainfield, Illinois 60544  
 (815) 609-1544 (815) 609-1670 (Fax)  
[www.bhes.us](http://www.bhes.us) Info@bhes.us

### BHES Behavioral Health Services Financial Policy

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 you the finest care, and would like you to understand that payment of your bill is necessary for maintaining quality care. For this reason, we have adopted the following financial policy which we require that you read, agree to and sign prior to receiving any behavioral health care services from us.

**Payment Responsibility:**

Since you are the individual seeking care, you are responsible for payment of all charges associated with your visits. As a courtesy and for your convenience, we will bill your insurance companies when you have provided us all the requested insurance information. You are responsible to pay your annual deductibles, co-payments, percentages (co-insurances), and uncovered services at the time the service is rendered (unless your insurance requires us to delay collecting of fees to a later date). If you are uncertain of your coverage, please contact your insurance company. If your insurance payment is not received within 60 days of our office billing your insurance company, you are immediately responsible for the full account balance.

If you choose not to bill your insurance for the care we provide you, or if you do not have insurance, it is understood that you assume financial responsibility for all charges. Also, if you are seeking treatment under workmen's compensation, please submit your employer authorization for treatment. Services will only be provided on a self-pay basis until the necessary authorization for treatment is received in our office.

**Referrals and Pre-Authorizations:**

Obtaining written or verbal verification of approval for services from your insurance company is your responsibility, and it is required in advance as a condition for treatment, as is the completion of our New Patient Registration Form.

**Missed Appointments:**

You are responsible to show up on-time for your scheduled appointments. You will be charged half of the full amount for missed appointments. This is your personal responsibility if you do not show up for or cancel your appointment at least 24 hours in advance of the scheduled appointment. Your insurance company will not cover this fee for you.

**Methods of Payment:**

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

**Returned Check Fee:**

A \$25.00 fee will be charged for any returned checks.

**Patient Billing:**

Patients who have outstanding balances are billed monthly. All balances are due 30 days from the billing date. When the account balance has not been paid within 30 days of the office billing date and you have not contacted the office regarding your account, your account may be referred to an independent collection agency. In that case, information that is helpful and/or necessary for collection purposes will be forwarded to our professional collection company. Once an account has been referred to collection, the office will provide additional services to the patient or the patient's family members **only** if the account is paid in full, or an arrangement has been made for the payment of the balance due. All costs incurred in the collection process shall be added to the original balance due.

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 claims related to my behavioral health care. Further, I request, from my insurance company, payment of my benefits to BHES for the services rendered.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**[Please present your driver's license and insurance card to the receptionist]**

\_\_\_\_\_ Initial here if you do not want BHES to bill your insurance.



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### Parent/Guardian Financial Agreement

It is the policy of Behavioral Health and Education Specialists (BHES) that in the case of separation or divorce, the parent bringing in their child for treatment is responsible to pay for the services rendered. It is understood that BHES will bill your insurance company according to normal procedures and as a courtesy to the patient. All deductibles, co-payments and co-insurances are included in this policy.

#### **Financial Responsibility:**

I, the undersigned, have read, understand and agree that I am personally responsible for the payment of all of the patient's fees to BHES for services rendered, including any fees not paid by my insurance company. I also understand that my health insurance policy is an arrangement between my insurance company and myself. In the event of default, I will pay legal interest, collection costs, and attorney fees in addition to the indebtedness for services rendered. I also authorize any behavioral health information necessary to process the claims related to my behavioral health care. Further, I request, from my insurance company, payment of my benefits to BHES for the services rendered.

Patient's Name: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Out of Network Acknowledgment

I, the undersigned, understand that the following BHES clinician: \_\_\_\_\_ currently is not an approved provider under my insurance, and I hereby understand and agree that I am personally responsible for the payment of \$ \_\_\_\_\_ or for \_\_\_\_\_% of all fees related to the services of this provider to me or the following members of my family: \_\_\_\_\_. Such payments are due at the time the service is rendered.

My preferred form of payment is: Cash \_\_\_\_\_ Check \_\_\_\_\_ or

Visa # \_\_\_\_\_

Expiration Date: \_\_\_\_\_

MasterCard# \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Discover Card# \_\_\_\_\_

Expiration Date: \_\_\_\_\_

American Express# \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for your consideration, we appreciate your patronage