Behavioral Health Clinic

New Patient Services Agreement

This form is an agreement between you, _____, and Behavioral Health Clinic (BHC). When we use the word "patient" below, it can mean you, your child, a relative or other person if you have written his or her name here: _____.

Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services and authorize BHC to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through BHC at any time.
By initialing this Consent to Treatment paragraph, I, the undersigned patient, acknowledge that I have both read and agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ Initials

Consent to Use and Disclose Your Personal Health Information

When we examine, test, diagnose, treat or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. With your consent, we may also share this information with others who provide treatment to you or need it to arrange payment for treatment or for other business or government functions. By initialing this paragraph, you are agreeing to let us use your information here and send it to others with your consent. The Notice of Privacy Practices (see attached) explains in more detail your rights and how we can use and share information. Please read this before you initial this Consent paragraph***. If you do not initial this consent paragraph agreeing to what is in our Notice of Privacy Practices, we cannot treat you.*** In the future we may change how we use and share your information with your consent and so may change our Notice of Privacy Practices. If we do change it, you may obtain a copy from your BHC clinician or by calling the BHC Privacy Officer at 715-842-9500.If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have initialed this consent paragraph, you have the right to revoke it (by writing a letter to the Clinic Privacy Officer at 3600 Stewart Avenue, Suite B, Wausau, WI 54401-3944 telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information with your prior consent and cannot change that.

_____ Initials **Clinician** Signature: _____

Financial Agreement

Fees: BHC is committed to providing the best treatment for our patients and we charge what is usual and customary for our geographic area. Online Counseling is a provided service that is covered by some insurance and is available for self-pay with services paid in full at time of service. For complex sessions, an additional $35.00 will be added to the charges for the day. Cancellation of scheduled appointments is required at least **24 hours** in advance. Failure to cancel within this time frame prohibits this office from scheduling other patients in that time slot. If a minimum of 24-hour notice is not received, the following shall occur:
For psychotherapy appointments – As a courtesy, this office waives the fee for the first missed appointment/late cancellation. After that, a charge of the full session fee will be billed to your account. Chronic missed/late cancelled appointments shall result in being placed on 'day-of' appointment scheduling.

Payment Information: Payment for services provided by BHC is the responsibility of the person receiving those services or, in the case of a minor, the parent/guardian signing this financial agreement. **Co-payments and deductibles are due at the time of service**. If no insurance is being billed, payment in full is due at the time of service. Minimum monthly payments of not less than $75.00 are expected on all outstanding account balances. If the balance is less than that amount, the balance is due in full. We are very willing to work with our patients on billing and insurance questions or payment for our services as we would like you to fully understand the process by which fees are applied. We also appreciate your cooperation with this process.

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Insurance Information: For your convenience, this office will file a claim with your insurance carrier for payment consideration. However, it is your responsibility to know the limits of your policy, maximum benefits and any managed care requirements. If your insurance carrier has a managed care requirement for mental health services, it is your responsibility to contact them prior to your first visit for any prior authorization that may be needed. Please notify this office with any change in insurance coverage, or if there is any secondary insurance information.

Changes to the Financial Agreement: We reserve the right to change the Financial Agreement, including fees, at our sole discretion and from time to time, without notice to you. If you do not agree to any amendments, you may stop using BHC services and terminate this agreement. Your continued use of BHC services after you are notified of any change will constitute your agreement to the change.

Authorization to Pay Services: I AUTHORIZE INSURANCE PAYMENT OF MEDICAL BENEFITS TO BEHAVIORAL HEALTH CLINIC (BHC) FOR SERVICES DESCRIBED ON THE ITEMIZED CLAIM FORM. I ALSO AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS THIS CLAIM. PAYMENT OF BENEFITS SHOULD BE PAID DIRECTLY TO: Behavioral Health Clinic. I RECOGNIZE AND ACCEPT PERSONAL RESPONSIBILITY FOR ALL SERVICES RENDERED AND WILL MAKE PAYMENT IN FULL OF ANY SELF-PAY CHARGES, CO-PAYMENTS OR DEDUCTIBLES AND FOR ANY BALANCE OUTSTANDING AFTER PAYMENT OR DENIAL OF SUCH INSURANCE BENEFITS.

_____ Initials **I HAVE READ THE FINANCIAL POLICIES AND AGREE TO MEET THEM.**

_____ Initials I am authorizing Behavioral Health Clinic (BHC) to charge my credit card for patient balances outstanding for more than 45 days, i.e. balances due from the patient that are not paid in full by the patient within 45 days of being notified of the charge. I further authorize BHC to disclose information about the patient's account charges to my credit card company if I dispute a charge. I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type (check one): ☐Visa ☐MasterCard

Card #: _____ Exp. Date: _____ CID:_____

Name Printed on Card: _____

_____ Initials **I am declining** to put a credit card on my account. I agree that if my account balance goes over $600.00 that services shall be disrupted.

Reminder Call/Text Agreement

Behavioral Health Clinic (BHC) provides courtesy reminder calls/text messages to remind you of your upcoming scheduled appointment. If you choose to receive reminder texts, please be advised there are some risks involved in communicating via unencrypted and unsecured text messaging, such as:

- Information sent to you by BHC may be opened and viewed by someone other than yourself whom you have given access to your phone number
- BHC may accidentally send the text message to the wrong phone number or you may accidentally send information to the wrong phone number
- BHC may erroneously transmit information to a different party that contains your appointment information
- BHC may erroneously transmit information to you containing a different party's appointment

Please provide a phone number and the way that you would like to receive your appointment reminder:

I choose to receive reminder **texts**. I authorize to have text alerts send to: (_____) _____ - _____

OR

I choose to receive reminder **calls**. I authorize to have reminder calls to: (_____) _____ - _____

_____ Initials **I agree** that I have read and understood the risks listed above and consent to transmitting information via telephone (via either phone call or text message) with BHC.

Behavioral Health Clinic

E-Mail Disclaimer and Consent

Behavioral Health Clinic (BHC) may transmit information to you or receive information from you via e-mail from time to time. Although, BHC utilizes a secure e-mail program, we understand that the receiver's e-mail program may not be secure.

Please be advised there are some risks involved in communicating via unencrypted and unsecured e-mail, such as:

- Information sent to you by BHC may be opened and viewed by someone other than yourself whom you have given access to your e-mail account
- BHC may accidentally send the e-mail to the wrong address or you may accidentally send information to the wrong address
- BHC may erroneously transmit information to a different party that contains some of your information
- BHC may erroneously transmit information to you containing a different party's information

E-Mail: _____

_____ Initials **I agree** that I have read and understood the risks listed above and consent to transmit e-mail back and forth with BHC.

Please sign stating that: **I HAVE READ THE POLICIES AND AGREE TO MEET THEM.**

Signature for **only** patients age 14-17: _____

Signature for ☐patient ☐parent ☐legal guardian: _____

Date: _____ BHC Representative: _____

*This form will be securely stored in your clinical file and may be updated upon request at any time.

(August 2018)