# Behavioral Healthcare Partners of Central Ohio, Inc.
# Payment Agreement

| *Client Name: | *DOB: | *Social Security Number: |
|---|---|---|
| | | |

**** Required information***

Behavioral Healthcare Partners of Central Ohio, Inc. (BHP) is a private, non-profit organization providing behavioral health services. Our organization believes that a good relationship depends upon good communication and a clear understanding of anticipated expenses.

**Fees for Service:**
This is being provided in order to better assist you in understanding the fee structure and the charges associated with mental health (MH) and alcohol and other drug (SUD) treatment services provided by BHP. During the intake process, BHP employees will discuss the services available to you and the costs associated with these treatment services. The projected costs for your treatment services will be based upon the financial information you provide for your household. As such, it is very important that you provide current and accurate information. BHP also posts the current fees for treatment services in each facility providing outpatient treatment services.

**Subsidized Fees for Service:**
BHP is a contract provider of Mental Health and Recovery for Licking and Knox Counties (MHR). As such, Licking and Knox County residents may be eligible to receive publicly subsidized services. This means that they may pay for the services you receive. However, there are strict regulations regarding how fees are determined. While fee schedules are generally reviewed and modified as needed annually, fees are subject to change at any time. BHP is required to apply the fee schedule established by the MHR Board to your household income in order to establish your subsidy (fee) for the services you receive from BHP (see below). Residents of other counties are not eligible for this sliding fee subsidy.

**Insurance/Medicaid/Medicare:**
BHP bills participating insurance companies as a courtesy to you. Please be sure that you provide us with current and updated insurance information at the time of your visit. You will be expected to show us your insurance/Medicaid/Medicare card at each visit. You are expected to pay your deductible/co-payments prior to receiving the service. If there is an unpaid balance after insurance payment has been made and any subsidy applied, it is your responsibility to make payment and you will be billed on a monthly basis. Payment is expected upon receipt of the statement unless you have made special arrangements with the Billing Department.

_____ **Please initial that you have read and understand the above paragraph on Insurance/ Medicaid/Medicare.**

**Refunds:**
Overpayments will be refunded upon written request to the responsible party within 30 days.

**Certifications:**
It is important for BHP to have documentation on record if clients do not have income or insurance, Medicaid, or Medicare. Please review the statements below and initial if any of the statements apply to you. As of the date of my signature, I certify that:

_____ I do not have any source of income.

_____ I do not have insurance, Medicaid, or Medicare.

_____ I have applied for insurance, Medicaid, or Medicare.

**Financial Information:**
It is important for BHP to have documentation on record of household income, number of people in the household and insurance information. Please provide the following financial information. This information is important to determine if you qualify for any type of assistance through our Community Mental Health Board.

$_____ **Total Household Gross** (before deductions) **Income** per month. Family income includes income received from wages/salaries, disability, etc. (do not include income from child support, unemployment or workers comp). Only include minor child's income if they are required to file taxes.

_____ Number of people in the household. Household includes dependents claimed on your annual taxes including yourself.

| **Current Address** | | | |
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| **Street Address:** | **City:** | **State:** | **Zip Code** |
| | | | |

| **County:** | **Phone:** | **Cell Phone?** ☐ Yes ☐ No | **OK to receive text message?** ☐ Yes ☐ No |
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| **Email Address:** |
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| **Mailing Address (if different from above)** | | | |
|---|---|---|---|
| **Street Address:** | **City:** | **State:** | **Zip Code** |
| | | | |

| **Primary Insurance** | |
|---|---|
| **Company:** | **Copy of Card Received?** ☐ Yes ☐ No |
| **Insured Name:** | **Insured Social Security #:** |
| **Insured Date of Birth:** | **Identification #:** |

| **Secondary Insurance** | |
|---|---|
| **Company:** | **Copy of Card Received?** ☐ Yes ☐ No |
| **Insured Name:** | **Insured Social Security #:** |
| **Insured Date of Birth:** | **Identification #:** |

| **EAP Insurance (For Employee Assistance Program Only)** | | | |
|---|---|---|---|
| **Company:** | | | |
| **Insured Name:** | **Insured Social Security:** | | |
| **Insured Date of Birth:** | **Identification #:** | | |
| **Authorization # for EAP:** | **Authorized # Sessions** | **Start Date:** | **End Date:** |
| | | | |

| Emergency Contact | | | |
|---|---|---|---|
| **Name:** | **Relationship:** | | **Phone:** |
| **Street Address:** | **City:** | **State:** | **Zip Code** |

**Acknowledgements:**

In signing this agreement I acknowledge the following:

- As outlined in the Notice of Enrollment form, I understand that I must authorize disclosure of information necessary for payment purposes in order to receive treatment services. My treatment or payment for my services cannot be conditioned upon my giving authorization for any purpose other than payment.
- I will provide true and accurate insurance and/or program eligibility information to qualify for any adjustments to the full cost of service. If I do not wish to use insurance and/or assistance programs (if available) or provide the required financial information, I will be expected to pay the full costs of service prior to receiving the service.
- I will assign benefits to BHP and authorize BHP to release to my insurance company my diagnosis and treatment information and/or the diagnosis and treatment information for my dependent, if applicable.
- I will immediately inform BHP if my income changes or if my eligibility for Medicaid, Medicare, Insurance, or other form of subsidy or assistance changes.
- I will make payment at the time of each visit to assure the balance of my account does not become a financial burden. I will pay using one of the following methods of payment: cash, personal check (in-state only), VISA, Discover, and MasterCard. There is a $25.00 service charge for each returned check. If two (2) or more checks are returned, I understand that BHP will no longer accept personal checks as a payment method.
- **I will contact the Billing Department at (740)788-0243 to make payment arrangements if I am no longer able to make payment in full. If arrangements are not made with the Billing Department and the required payment is not received, an overdue balance may delay continuation of services. If arrangements are not made within 90 days of my account becoming delinquent, BHP reserves the right to use a collection agency. If this becomes necessary, all non-crisis services will be stopped until the account is collected. Clients with account balances over $300 who have not made payment arrangements will not be rescheduled for future appointments until payment arrangements are made.**

  _____ **Please initial that you have read and understand the above paragraph.**

- I have been provided a copy of this signed document for my records (upon request) and have received notification of current rates for the services I may receive. Notification of rate changes will be posted in each facility.

I acknowledge that I have access to the BHP Orientation Manual via the organization's website (www.bhcpartners.org) or have been given a paper copy that includes the following:

- Advance Directives
- Client Rights Policy
- Client Rights Grievance Policy
- BHP Notice of Privacy Practices
- MHR Notice of Privacy Practices

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|---|---|
| **Client Signature:** | **Date of Signature:** |
| **Authorized Representative Signature:** | **Date of Signature:** |
| **Witness Signature:** | **Date of Signature:** |