Missouri River Health
425 East Ave C
Bismarck ND 58501

Today's Date: _____

Client's Name: _____ Gender: _____

Date of Birth: _____

Address: _____
Street Address City State Zip Code

Responsible Party: _____ Address: _____

Home Telephone Number: _____ Cell Phone Number: _____

Email Address: _____

Spouse's Name: _____ Telephone Number: _____

If Child, Father's Name: _____ Telephone Number: _____

If Child, Mother's Name: _____ Telephone Number: _____

Primary Care Physician: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Telephone Number: _____

INSURANCE/PAYMENT INFORMATION: *Please check the appropriate insurance/payment option and complete its designated section.*

** *Please note: You, the client, are responsible for knowing and understanding your insurance coverage/benefits. It is the client's responsibility to call their insurance company to verify services before services are rendered.*

Medicaid: Medicaid Number: _____

Medicare: Medicare Number: _____

BCBS or: Sanford Health: Policy Holder Name: _____ Date of Birth: _____ of Policy Holder

Policy Number: _____ Group Number: _____

Other Insurance: Company Name and Address: _____

Policy Holder: _____
Name and Date of Birth

Policy Number: _____ Group Number: _____

Self-Pay: _____ **Please note that it is required that self-pay clients pay for services prior to the services being rendered.

Authorization: I hereby authorize Missouri River Health to furnish information to insurance carriers concerning any services rendered to me or any member of my family, and I hereby assign to Missouri River Health all payments for services rendered. I understand that I am financially responsible for all charges.

Signature: _____ Date: _____

Missouri River Health

AUTHORIZATIONS AND RELEASES

Client Name: _____

*Please **READ** each item, **INITIAL** each item and then **SIGN** and **DATE** on the bottom of this form.*

1. _____AUTHORIZATION FOR EVALUATION/TREATMENT

I hereby authorize the professional in charge of the above-named client to evaluate and administer treatment necessary or advisable.

2. _____LIMITS OF CONFIDENTIALITY

I understand the limits of confidentiality as outlined on the reverse side of this form.

3. _____RELEASE OF INFORMATION FOR INSURANCE CLAIMS

Missouri River Health is authorized to release all or part of the client's medical record to any person or corporation which is or may be liable for any part of the clinic's charges, including but not limited to, hospital or medical service companies, insurers, compensation carriers, or government agencies. It is understood that a photocopy of this form is a valid authorization for release.

4. _____ ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the client or any party liable to the client, directly to Missouri River Health. I understand that I am financially responsible for any charges not covered by this assignment.

5. _____MEDICARE SIGNATURE ON FILE

I hereby authorize payment of Medicare Benefits be made either by me on my behalf to Missouri River Health for any service furnished me by the listed provider. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the client is responsible only for the deductible, coinsurance and noncovered services.

6. _____FINANCIAL RESPONSIBILITY

In consideration of the services to be rendered to the client by the provider, the undersigned guarantees that payment of any amount due. I have read the Statement of Financial Understanding on the back of this form, and I assume financial responsibility for the expenses of the above-named client.

7. _____CERTIFICATION

I hereby certify that I have read each of the above statements, and being the client, guarantor, or being duly authorized by the client, do agree and accept its terms.

_____ _____

Client or authorized signature Relationship to Client

_____

Date

Missouri River Health

STATEMENT OF FINANCIAL UNDERSTANDING

BILLING POLICIES

As a service to our clients, Missouri River Health is capable and willing to assist you with filing insurance claims and answering any billing questions. All information requested is necessary for the proper processing of claims, and to speed up the billing process. Without this information, the bill will be sent directly to you.

Missouri River Health will not accept the responsibility for collection of insurance claims or negotiate settlements in disputed claims. Please recognize that you, the client, are responsible for the bill. If problems arise in the processing of these claims, we will provide any assistance possible.

MEDICARE BENEFITS

Missouri River Health is a participant in the Medicare Program and does accept Medicare assignments. We will be happy to submit any balance following payment from Medicare to your supplemental insurance providing complete information is furnished.

WORKERS COMPENSATION

North Dakota Workers Compensation claims are submitted directly to the Workers Compensation Bureau by Missouri River Health. If the Workers Compensation is through another state, the claim will be completed by our office and sent directly to you for submission to your individual Workers Compensation Insurance Fund.

NO FAULT

If your visit to the clinic is due to a motor vehicle accident, you will be asked for the name and address of the insurance company along with the claim number and date of accident. If you cannot provide this information, we will consider the balance your responsibility.

PAYMENT PROCEDURES

Benefits paid directly to Missouri River Health are credited to your account and you will be notified on the statement of any balance due.

When benefits are payable directly to you, you are responsible for submitting that payment to the clinic. At that time your account will be credited, and you will be notified in the next statement of any balance due.

We understand there are clients who have financial difficulties and encourage them to discuss their situation with us so payment arrangements can be made.

Missouri River Health will not extend credit to a client who fails to make payments, unless you consult with our office. These accounts may be turned over to an outside agency for collections. Payment arrangement can be made by calling (701) 712-9962.

CONFIDENTIALITY

The staff of Missouri River Health does everything possible to assure your confidentiality. Your limits to confidentiality may be limited by law or regulations in some situations, such as

1. the person who is harmful to him/herself or others
2. disclosure of suspicion of child abuse or neglect previously unreported
3. a court ordered request for records, or
4. access by the support staff directly providing your care or completing quality assurance activities

Other considerations:

1. In the case of a minor or child, we reserve the right to communicate with client or guardian.
2. Older children, especially teens, will be allowed the same privacy as an adult; parents/guardians will be offered suggestions in enhancing their care.
3. CELL PHONES: Cellular telephones and cordless telephones are UNSECURE. Missouri River Health does not recommend using any cellular and/or cordless telephones to communicate with any of the providers regarding mental health issues. It is to be understood if you choose to communicate with any provider over any cellular telephone or cordless telephone regarding mental health issues Missouri River Health is NOT RESPONSIBLE for any overheard conversation that occurs over the electronic waves/transmission of the cellular telephone or cordless telephone.

MISSOURI RIVER HEALTH

BILLING PROCEDURES AND POLICIES

Missouri River Health will submit claims to the client's insurance provider. To do so, a copy of the client's insurance card will be made. It is the client's responsibility to notify the office of any change in address, phone number, or insurance carrier. If you **DO NOT HAVE INSURANCE,** we require payment **prior** to receiving mental health services.

CO-PAYMENTS:

If you have a **co-payment** for mental health services, the **co-pay is due the day services are rendered.**

Payments are expected within 30 days after you receive your statement. Statements will be mailed to the address you provide us. If you are unable to pay your balance in full, we can discuss a payment plan. We accept cash, credit cards and checks for payment. There will be a $25.00 charge on all returned checks.

If your individual balance exceeds 250.00 or $1,000.00 for multiple family members, treatment will be suspended for all members, and no new appointments will be scheduled until your balance is brought to good standing.

COURT FEES:

All fees related to legal proceedings will be billed to the individual patent and are not reimbursable by insurance.

PLEASE NOTE: COLLECTION PROCEDURES:

Clients will be sent statements monthly. The client will be notified if the balance is past due. After 60 days with no payments or effort to arrange payment, services will be terminated. Overdue accounts will be turned over to our collection agency who will seek payment. If the client account is turned over to collections and client requests to return for services, exceptions may be made; however, the patient will also be responsible for the commission fees paid to the collection agency.

NO SHOW POLICY:

We ask that our office be notified as soon as possible if the client is unable to keep an appointment. We would prefer 24-hour notice. This allows us to reschedule other clients to access the time slot. After three consecutive cancellations and/or "no shows" services may be terminated, per discretion of the provider or business manager. Late cancellation and no-show fees will be as follows: First occurrence: $25.00, Second occurrence: $50.00, Third and consecutive occurrence: $100.00. Clients who arrive 15 or more minutes late will be required to reschedule their appointment.

MINOR CHILDREN:

The office and employees of Missouri River Health **are not** responsible for minor children left in the waiting room area unattended.

VALUABLES:

The client is responsible for the retention of personal articles. Missouri River Health will not assume responsibility for the loss or any damage of client's personal articles (e.g. money, jewelry, eyeglasses, dentures, hearing aids, cell phones or other electronic devices, or clothing, etc.).

TERMINATION OF SERVICES:

(a) Providers may terminate services when it becomes reasonably clear that the client no longer needs or no longer benefits from the service.

(b) The provider will terminate therapy when threatened or otherwise endangered by the client or other person with whom the client has a relationship.

(c) Services will be terminated for failure to comply with billing policy.

(d) Services will be terminated if the client's outstanding balance has been turned over to collections.

(e) Services will be terminated if a client has filed for bankruptcy and there is an outstanding account balance.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

Missouri River Health is authorized to release confidential mental health/behavioral health/chemical dependency/protected health information to the following:

1. All health care providers, professionals, and/or agencies to which the patient is transferred or referred for follow-up medical care, treat, or the primary care physician.
2. All individuals, entities, Social Security Administration and 3rd party payers.

The client and individual legally obligated to pay for mental health services agrees to pay and is financially responsible for the services provided.

I assign and authorize any third-party payer/insurer to make direct payment to Missouri River Health. I authorize the refund of overpaid insurance benefits to the insurance company.

I acknowledge that I have read the front and back of the office procedures and billing policies of Missouri River Health and have agreed to their terms.

_____ _____

Client Signature (or Authorized Signature) **Print Name**

_____

Date

OFFICE PROCEDURES AND BILLING POLICIES

ADDENDUM

LATE CANCELLATION AND NO-SHOW POLICY

Clients are expected to cancel or reschedule all appointments 24 hours in advance. Clients will be responsible for the following late cancellation and no-show fees:

First Occurrence: $25.00
Second Occurrence: $50.00
Third & Subsequent Occurrence: $100.00

Clients will be responsible for paying these late cancellation and no-show fees because their scheduled sessions are time commitments that are made and held exclusively for them.

Cancellations and rescheduled sessions will be assessed on a case-by-case basis. If the client is late for a session, they lose that session time. Clients who arrive 15 or more minutes late will be required to reschedule their appointment.

Services will be terminated if a client does not show up for three consecutive appointments, per the discretion of the provider or business manager.

Client Name Printed: _____

Client Signature: _____

Date of Signature: _____

Payment Authorization Form

Client Name: _____
Client Phone Number: _____

Name on Card: _____
Card Number: _____
Card Expiration Date: _____
Security Code: _____

Billing Address: _____
Zip Code: _____

I authorize Missouri River Health to charge my payment method on file for any balances, including late cancellation and no-show fees, without additional authorization. I understand that my information will be saved to a secure file for future transactions on my account.

I agree to notify Missouri River Health if my account information changes. I certify that I am an authorized user of this credit card and will not dispute these transactions as long as the transactions correspond to the terms indicated in this authorization form.

Client's Signature: _____

Date of Client's Signature: _____