



Kelly Birch, LPC
Billing Information

∞ This form is required for all patients regardless of insurance coverage status ∞

Patient Name:		DOB:	Gender (according to insurance documents) <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			
City:	State:	Zip:	
Phone #:	<input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home/Landline	Preferred method of contact: <input type="checkbox"/> Text (SMS) <input type="checkbox"/> Email	
Alternate Phone #:	<input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Home/Landline	(If neither is indicated, we will use secure email)	
Email:			

Initial here if you have no insurance coverage **OR** you do not want your insurance billed.

Do you have coverage with any of the following? (Check all that apply)
(Please attach an additional copy of this page to share information about all other insurance coverages)

EAP Medicaid (OHP) Medicare Other Insurance

Insurance Company: _____ Phone: _____

This policy is (check one): Primary Secondary

Primary Insured Name & DOB: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

ID#: _____ Group # _____

This policy is (Check one): Health Insurance EAP Worker's Compensation Auto Insurance Other

Address: _____

***** PLEASE ATTACH A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARD(S) *****

I have been given an opportunity to read the Billing Disclosure (attached), and I hereby authorize the provider named above, and appointed billing agent(s) to provide summary of care and assessment information regarding evaluation and/or treatment of the patient named above for the purpose of evaluating and processing claims for benefits. **I have completed this form correctly and completely to the best of my knowledge, disclosing all payer(s) that cover me. I understand that providing incorrect or incomplete information on this form may result in a higher than expected out of pocket expense for me. I will contact the billing office if any of the information reported on this form changes.**

Signed: _____ Date: _____
 Relationship: **Self** Other (Print Name) _____ (Relationship) _____
Please return completed form to the billing office: info@professional-practice.org or Fax (503)419-4662.



Kelly Birch, LPC
Billing Information

Billing Information Disclosure

Thank you for completing your billing information form and attaching a copy of the front and back of your insurance card(s). Please review the information below to be familiar with the billing process. We would like to keep your out-of-pocket expense as low as possible, and we need your cooperation to make that happen.

∞ The billing information form is necessary for all patients, whether you are covered by insurance or not. If you have insurance, be sure to fill in your ID# and Group # on the billing information form **and also** send a copy of your insurance ID card. Completing this form improperly may result in an inaccurate estimate and greater than expected out-of-pocket expense for you.

∞ **Good Faith Price Estimate.** The billing office will reach out to you with a good faith price estimate for routine services by secure email (to the email address that you fill in on the billing information form attached) or text message within three business days of receiving your completed billing information form and a copy of your insurance card(s). If you have not received a good faith estimate within three days of sending your completed forms, please contact our office directly (**email: info@professional-practice.org / Phone (541)234-4781**). **Please note that this is a good faith estimate based on information provided by you and your insurance company, not a guarantee of payment. Final benefit determination will be made by your insurance company after they have received your claim.** We encourage you to contact your insurance company verify your benefits and the terms of your plan. The billing office can provide you with a Patient Price Estimate Worksheet for gathering information to verify your benefits. In some cases, a Patient Price Estimate Worksheet completed before services were rendered can support an appeal if your insurance processes claims differently than they said they would.

∞ **Carve-Out Plans.** Occasionally, insurance plans will carve out mental health benefits to another company. (In other words, you may have medical insurance with one company, but your mental health claims may be processed by another company.) We can find out about situations like this during the price estimate. If your mental health benefits are carved out to a company that your provider is out of network with, you may have a higher than expected out of pocket expense for treatment. Please be sure to return your insurance information form to the billing office at least 10 business days before your first session so that you have the opportunity to review your estimate before services are rendered.

∞ **Changes. Please contact our office immediately if anything reported on the Billing Information form changes.** In some cases, a change of your information will change your out-of-pocket expense for treatment, even if the type of treatment that you are receiving doesn't change. We may not be able to bill your insurance or warn you of increased out-of-pocket expense if we don't have current information at least 10 days before changes become effective.



Kelly Birch, LPC
Billing Information

⌘ **EAP Benefits.** If you have Employee Assistance Plan (EAP) benefits, your EAP may be managed by a different company than your medical insurance. If you would like to use your EAP benefits, please contact your EAP to make sure that the provider you are seeking treatment with is in your EAP network. Most EAP plans will not pay for services with an out-of-network provider. We cannot bill your EAP if we don't have your EAP authorization information in writing from your EAP administrator prior to treatment. If you want us to bill your EAP, please send a copy of your EAP authorization letter/email to our office with your Billing Information form so that we can bill your EAP. In some cases, we may not be able to bill EAP plans retroactively, so it is especially important that you send a copy of your EAP authorization with your Billing Information form to ensure that your EAP can be billed. If you fill out your billing information form with your medical insurance information, your medical insurance will be billed, and your EAP benefits will not be applied.

⌘ **Dual Coverage.** If you are covered by more than one insurance plan, please attach additional copies of the Billing Information form completed with your other insurance information and a copy of the front and back of all insurance cards for all plans and policies that cover you. **Please include this information even if you don't think that your other insurance will cover the treatment you're seeking.** If your insurance denies your claim because they think that another payer should be billed first (also known as 'Coordination of Benefits' (COB)), we will send you a statement for the balance due, noting that your insurance refused to pay, indicating that you have another coverage that should be billed first. In that event, you would need to contact your insurance company and provide the information that they need in order for your claim(s) to be reprocessed and then contact us to follow up so that your claims can be resubmitted. If we don't hear from you within 30 days of your statement to indicate that you provided the information required by your insurance company and we don't receive updated insurance information from you before the deadline established by your primary insurance company for timely filing, you may be liable for the entire balance of the claim, as established in ORS 410-120-1280(5).

If you have any questions, please contact the billing office:

Phone (541)234-4781 / Email: info@professional-practice.org / Fax (503)419-4662

Mail: PO Box 503010, White City, OR 97503-0813

Patient Portal: <https://portal.kareo.com/app/new/login>

Thank you.

Professional Practice



Kelly Birch, LPC
Fee Agreement

Patient Name:	Patient DOB:
Guarantor Name:	Relationship of Guarantor to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Other: _____
Guarantor Mailing Address:	Phone:
Guarantor Email:	

Guarantor: a person responsible for account payment. The patient and guarantor may or may not be the same person.

The standard fee at Kelly Birch's office (my Provider), is \$150.00 per routine session for outpatient mental health counseling. My treatment may include any of the codes and services listed on this form (page 2) depending on my treatment plan.

My signature below indicates that I am financially responsible for the patient account identified above according to the terms of this agreement below.

--	--

Guarantor Signature

Date

- ✓ I am prepared to pay my estimated balance to my Provider prior to each session, as well as all fees not covered by insurance.
- ✓ I understand that if my copay, coinsurance, or other balance and associated fees are not paid within 30 days of being invoiced, or I provide incomplete or inaccurate billing information, a \$9 billing fee may be assessed.
- ✓ I understand that my healthcare coverage is between me and my insurance company. I will be ultimately responsible to know the terms and exclusions in my plan, and to ensure my payer's cooperation with my Provider's office. If no insurance payment has been received by my Provider within 60 days of billing, I will be responsible to pay the unpaid balance on my account. I will be promptly reimbursed if my Provider subsequently receives payment.



Kelly Birch, LPC
Fee Agreement

- ✓ I understand I will be responsible for paying a **fee for missed appointments** when 24-hour prior notice is not given (No Show*), and my insurance company will not be billed.
- ✓ If my insurance policy or another third-party coverage denies my claim, I may be responsible for paying the Standard Fee unless prohibited by law.
- ✓ My Provider has a legal right to utilize a collection or billing service to collect payment from me if I fail to pay in full for services received, and to refuse services until such payment is made. ***My Provider has the right to impose additional fees of up to 50% if my account is referred for collections.***

Standard Fees (Patient out-of-pocket expense if not covered by insurance)

CPT Code	Brief Description	Fee
90837	Psychotherapy – 60 minutes	\$150.00
No Code	Couples Therapy – 90 minutes	\$250.00
No Show*	Appointments missed without 24-hours' notice	Full Fee

No other costs are anticipated as part of this treatment.

I will contact the billing office with the information below if I need to do any of the following:

- ✓ Provide updated information
- ✓ Cancel or rescind this fee agreement
- ✓ Ask questions or voice concerns
- ✓ Arrange for payment of my balance
- ✓ Apply for a discount or payment plan due to financial hardship

Professional Practice • Phone (541)234-4781 • Email: info@professional-practice.org

Mail: PO Box 503010, White City, OR 97503



Rev 12/16/2021 PPL

Kelly Birch, LPC

•Phone: (541)234-4781 • info@professional-practice.org • PO Box 503010, White City, OR 97503-0813•

Credit Card Authorization

Please complete this form to authorize the office named above to charge your credit card for your balance.

Name as it Appears on Credit Card

Address (including city, state, and zip code) as it appears on Credit Card Statement

Patient Name

Credit Card # _____ Expiration Date: _____ Auth Code _____

Type **(Circle One)**: Visa Master Card American Express Discover

Unless an option is completed and initialed below, I am authorizing my provider's office to charge the above credit card after session(s) for the balance due on my account per my insurance company's determination or per my fee agreement with the provider in the absence of insurance determination until my credit card expiration date above.

Cardholder Signature

Date

OPTIONS: To amend the above bolded statement, complete and initial an option below:

___ **SINGLE** • I authorize a single charge of \$ _____ to be charged on _____ (date).

___ **INSTALLMENT PLAN** • I authorize an installment plan of \$ _____ per (Month or Week) starting _____ (date) for # _____ installments, totaling \$ _____.

___ **FLEXIBLE INSTALLMENTS** • I authorize a recurring charge of up to \$ _____ (my estimated copay/coinsurance, per session).

___ **OTHER** • I attached details of my authorization to charge my card (subject to Provider approval).



Kelly Birch, LPC

Authorization to Release Protected Information

Patient Name:	DOB:
----------------------	-------------

This form is optional. I authorize my Provider indicated above (and appointed staff and billing agent) to use and disclose specific health information described below (according to ORS 192.559) to:

Name:	Phone:
Mailing Address:	
Email:	

Specific information to be released: Clinical Information Financial & Accounting Information

Other: _____

Purpose of Release: Coordination of Billing (and Other *(if applicable)*): _____)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information	_____ Genetic testing information
_____ Mental health information	_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Tracy Gonzalez / Professional Practice, LLC at PO Box 503010, White City, OR 97503-0813 or by fax to (503)419-4662 or by email to info@professional-practice.org . State your name, the patient's name, the patient's date of birth, and state that you are revoking this authorization to release information.

I have read this authorization and I understand it. This authorization expires at the conclusion of treatment unless another date or event is described below.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: Self Other: _____