Buffalo Grove Sleep and
Behavioral Health

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Agreement to Pay for Professional Services

Welcome to Buffalo Grove Sleep and Behavioral Health. This document contains important information about our professional services and financial policies. Please read this contract carefully and discuss any questions or concerns you might have with Dr. Strain.

I request that Buffalo Grove Sleep and Behavioral Health and its practitioners provide psychological and consulting services to:

_____

Please print name of patient above.

I understand that if I choose to use insurance, Buffalo Grove Sleep and Behavioral Health will contact my insurance company to inquire about available mental health benefits, and will share that information with me as a courtesy only, and not as guarantee of payment.

I understand that if my insurance is a "managed care" type of benefit, Dr. Strain may be required to submit a treatment plan to the managed care contractor. This usually includes diagnosis, description of the problem, personal background information, treatment goals and therapy methods. My signature gives Buffalo Grove Sleep and Behavioral Health the permission to submit this information on behalf of myself (or my minor) if I choose to utilize my insurance benefit.

I understand that payment is due at the time of service. If benefits have been verified, I am responsible for the co-pay portion at each session. Otherwise, I will pay in full.

If my insurance carrier changes, I agree to contact Buffalo Grove Sleep and Behavioral Health with that information and readjust my co-pay accordingly if necessary.

I agree to contact my insurance company to expedite payment to Buffalo Grove Sleep and Behavioral Health if payments are not made promptly (over 30 days). I also agree that in the event that I receive insurance payments directly from my carrier, I will promptly remit that amount of payment to Buffalo Grove Sleep and Behavioral Health.

I understand and agree to give 24 hours prior notice if unable to keep an appointment. Since insurance companies cannot be billed for missed appointments, I understand that it is my sole fiscal responsibility. Late cancellations due to illness or emergency will be discussed on a case-by-case basis.

I understand that Dr. Strain may be required by law to release information without my approval to a specific professional and others if there is a clear and serious danger of harm to anyone, a judge requires specific information in a court case, and/or it is suspected that a criminal offense of child abuse has occurred.

I understand that this consent can be revoked at any time by submitting a written note to Buffalo Grove Sleep and Behavioral Health.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

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Signature of Patient/Guardian Date

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Witness Date