



Payment & Insurance Information

As a courtesy to our patients, we can file your bill to your insurance company. It's much easier for the both of us if we have the right information up front. If you have questions about how the billing process works, feel free to call or browse through our frequently asked questions page on our website.

A word of protection for our patients:

- Your treatment with us may be covered by a different insurance than a visit with your family doctor. *You can usually find on the back of your insurance card the mental/behavioral health phone number if you are unsure.*
- Some providers may NOT be in network with your insurance company. *You can contact your insurance company and give them the name of the provider you are wanting to see.*

We do our best to schedule your appointment with an In Network provider, however we have found that certain insurances outsource their mental health coverage processing to a completely different company (Blue Cross Plan XYZ may cover a primary care physician office visit while sending mental health claims to United Behavioral Health Plan ABC). The issue with this is while your provider may in fact be In Network with the insurance company named on your card, they may out of network if the claims are sent elsewhere.

In our example above, the provider was not in network because the mental health coverage is with a different company. Most of the time, it is easy for us to determine if this is case and generally there are only a few insurance companies that do this. We strongly recommend that you speak with your insurance company to determine where the mental health (sometimes referred to as behavioral health) coverage is processed. *We will pass on to you what your insurance tells us you owe.* This means that if the insurance company tells us we have the wrong company, the wrong date of birth, the wrong ID etc., or to apply out of network coverage, you will be responsible for the payment according to your coverage.

Please note, some visits will require an authorization and/referral. We know that Humana will require your primary care physician to send us a referral to treat you. Some psychological testing may require approval prior to your visit.

Please fill out the areas below as accurately as possible:

EMAIL or Fax or Send or Bring a copy of your insurance card(s)

Email- appointments@barnabashealthcare.com

Fax- 803.216.0420

Patient Name:	_____	Patient Date of Birth:	_____
Primary Insurance:	_____	Patient SSN:	_____
Insurance ID:	_____		
Insured By:	_____	Relationship to Insured:	
Insured by Date of Birth:	_____		
Insurance Address:	_____		
Mental Health Phone:	_____		
Secondary Insurance:	_____		
Insurance ID:	_____		
Insured By:	_____	Relationship to Insured:	
Insured by Date of Birth:	_____		
Insurance Address:	_____		
Mental Health Phone:	_____		

I do not have insurance and acknowledge that I am responsible for my bill at the time of service.

Who is responsible for your bill?

AUTHORIZATION FOR PAYMENT

For convenience, we offer different payment options. You can call us after your visit to pay over the phone, pay through the patient portal or we can store a credit card on file for you. If you have any questions about your balance, feel free to call our billing team or send a message through the portal. We will not schedule follow up visits with an outstanding patient balance. Standing appointments require a zero balance weekly or to have a card on file for payment. If you would like to setup a card on file, please fill out the following information. If you chose to place a maximum debit amount and have any questions regarding what your portion of your bill will be (self pay or insurance), we are happy to help.

Please select from the following drop down list the method you will prefer to make payment.

[Click to Make Selection from Dropdown](#)

Card on File for Payment Information

Card Number:	_____	Type of Card:	_____
Name on Card:	_____	Expiration Date:	_____
Billing Address:	_____	CITY/STATE/ZIP:	_____
	_____	CVV:	_____

Please indicate your preference.

INITIALS ___ I give permission to Barnabas Behavioral Healthcare, LLC to bill my credit card on file

[Click to Make Selection from Dropdown](#)

Specific Dates for Billing If Needed

[Click to Make Selection from Dropdown](#)

Up to Maximum Debited If needed \$_____

Signature

Date