Southern Minnesota Behavioral Health
Payment for Services

Client Name:	**Date of Birth:**
Street Address:	**County of Residence:**
City, State, Zip:	**Phone:** **Circle:** ☐ Home ☐ Cell ☐ Work
Case Manager Name (if applicable):	**Phone:**

(1) Payment Method (Please check one)

☐ I do not have health insurance, and I agree to pay Southern Minnesota Behavioral Health Center full fees as due.

☐ I have health insurance but choose not to submit claims for this service to my provider, and will pay all amounts due.

☐ I have private health insurance or medical assistance, and I agree to pay in full to Southern Minnesota Behavioral Health Center any balance due for services not covered by my health insurance, including spend-downs, co-pays and deductible amounts. My insurance card for primary, secondary, and tertiary coverage is attached for copying. My information is:

Subscriber (primary insured) name _____ Subscriber date of birth _____ Subscriber Social Security # _____ Will provide card ☐

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(3) Medicare/Medicaid Clients ONLY

ADVANCE NOTICE OF NON-COVERAGE

Your provider _____ is currently not credentialed with Medicare. You are currently able to see this provider as you have a secondary insurance _____ hat will cover the visits. In the event that you no longer have this secondary Medicaid coverage, you will need to pay in full for those services or switch to a Medicare credentialed provider (as available).

This notice gives our opinion, not an official Medicare decision. If you would have any questions or concerns regarding this notice, you may also contact Medicare billing by calling 1-800-633-4227.

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(4) Signature Required:

Client Signature _____ Date _____

Statement of Legal Guardian: By signing below I am stating that I am the legal representative of this client, and have the authority to sign the above representations on his/her behalf. If there is another party whose consent is also needed (as in joint legal custody) I agree to provide that information.

Printed Name of Legal Guardian _____ Relationship to Client _____ Reason Client Cannot Sign _____

Signature of Legal Guardian _____ Date _____