MINDPATH HEALTH

Acknowledgment of Financial Responsibility

Please sign below to indicate your agreement.

Insurance authorization

I authorize Mindpath to act as my agent and disclose my health information to my insurance company to obtain payment for services rendered. I understand I am financially responsible for all charges not covered by my insurance plan. If I have a Medicaid plan, I understand I am only financially responsible for the copay and share-of-cost amounts.

Accurate insurance information

I agree to provide Mindpath Health with accurate and complete insurance information and to communicate any changes to my insurance information. I agree to pay for any cost that results from coverage lapses due to incomplete or inaccurate information.

Outstanding balances

If my balance becomes past due, I agree to comply with a payment plan if offered. I understand my provider may terminate treatment for non-payment. Accounts greater than 60 days may be referred to a debt collection agency.

Payment for minor patients

I understand that payment is expected on the date of service whether or not a minor is accompanied to an appointment. My credit card on file will be charged for services rendered.

Payment authorization

I authorize payment directly to my provider, and hereby assign my right to reimbursement for services rendered to Mindpath Health. I understand that my credit card on file will be charged for services rendered.

Payment by check

I understand that if two check payments are declined due to insufficient funds Mindpath Health will no longer accept checks as a form of payment. Additionally, I will be charged any fee associated with invalid checks.

I understand that this Acknowledgement of Financial Responsibility will remain in effect until I provide written notice of cancellation to Mindpath Health. I permit a copy of this authorization to be used in place of the original.

Patient Signature	Date
Print Name	Patient Date of Birth

If you are signing this Acknowledgement of Financial Responsibility as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Health Care Surrogate
- ☐ Power of Attorney for Health Care
- ☐ Executor / Administrator

Signature _____ Date _____

Name _____