MINDPATH HEALTH

Acknowledgment of Financial Responsibility

Please sign below to indicate your agreement.

Insurance authorization

I authorize Mindpath Health 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