MINDPATH HEALTH

SELF-PAY AGREEMENT

I, _____, understand and agree:
Patient Name

1. I represent that (check appropriate box below):
   - ☐ I am not currently enrolled in or eligible for Medicare or Medi-Cal.
   - ☐ I am not seeking treatment for a work-related injury or for assistance with disability paperwork.
   - ☐ I have health insurance coverage; however, Mindpath Health does not currently accept my health insurance plan.
   - ☐ Mindpath Health accepts my health insurance plan which may cover some or all the services rendered to me by Mindpath Health, however I have instructed Mindpath Health not to submit claims to my health insurance plan and agree to forego the ability to submit claims to my health insurance plan directly for services rendered to me.
   - ☐ I do not currently have health insurance coverage.
2. I elect to self-pay for all services I receive from Mindpath Health.
3. Mindpath Health's fees for routine services are as follows:

Service Type	MA/Therapist	Psychologist	Nurse Practitioner	Psychiatrist
Initial Evaluation	$280	$315	$475	$560
Follow-up Session*	$150-$270	$230-$300	$330-$390	$390-$455
No Show/Late Cancellation	$50	$50	$50	$50

*Follow up session rates are based on complexity of care determined by your provider

4. Mindpath Health requires payment of $150.00 the same day of services rendered; you will be billed for the remaining balance based upon services provided. Pricing is determined upon the care provided. If you would like a full schedule of pricing, please request from Front Office staff.
5. I agree to pay a deposit of $150.00 which will be applied to the services I receive from Mindpath Health at the time of my visit, and can keep a confidential HSA, HRA, FSA or credit card on file to auto-pay for services rendered at the time of service.
6. In the event I no longer wish to self-pay for services I receive from Mindpath Health, I agree to notify Mindpath Health in writing and provide Mindpath Health within network third-party payment information as appropriate. I understand that such change in my financial information will become effective upon receipt by Mindpath Health and will not apply to services rendered to me prior to that date.

By signing below, I certify that I have read and agree to be bound by this Self-Pay Agreement.

_____ _____
Patient Signature Date

_____
Patient Name

If a party other than the patient is financially responsible for payment for services rendered to the patient, please sign below.

_____ _____
Financially Responsible Party Signature Date

_____
Financially Responsible Party Name