MINDPATH
HEALTH

Patient Self-Pay Agreement

This Self-Pay Agreement is intended to provide patients and parents/legal guardians with an understanding of their financial responsibilities should they elect to self-pay for Mindpath Health's services.

By signing this agreement, I, ___________________________________ (patient or parent/legal guardian), understand and agree that:

1. I am not currently enrolled in or eligible for Medicare, Tricare or Medicaid.
2. I am not seeking treatment from Mindpath Health for a work-related injury or for assistance with disability paperwork.
3. I represent that (check appropriate box below):

   ☐ 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 of 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.
4. I elect to self-pay for <u>all</u> services I receive from Mindpath Health.

Mindpath Health's default uncontracted rates for routine services are as follows. Participating in-network insurance discounts may apply, reducing patient responsibility amounts.

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Service Type	Psychologist/Therapist	Psychiatrist/Nurse Practitioner/ Physician Assistant
Initial Evaluation	$145-$242	$322-$426
Follow-up Session*	$64-$204	$124-$343
No Show/Late Cancellation	$70	$70

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

Should I or my child become a self-pay patient:

- I agree to pay Mindpath Health for services rendered at the time of my visit.
- I agree to provide Mindpath Health with a valid credit card to be kept on file and authorize Mindpath Health to charge my credit card for services rendered at the time of service.

- I agree to notify Mindpath Health in writing if I no longer wish to self-pay for services and provide Mindpath Health with third-party payment information as appropriate. This change in 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 **Patient Self-Pay Agreement**.

____ _______________________
Patient Signature Date

____
Patient Name

If someone other than the patient is financially responsible for payment, please sign below.

____ _______________________
Financially Responsible Party Signature Date

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Financially Responsible Party Name

Questions may be directed to Mindpath Health Customer Service at 855-501-1004