PATIENT FINANCIAL AGREEMENT

Thank you for choosing iMind Mental Health and Wellness for your care. We are committed to the success of your treatment and realize that communication is vital to the patient's wellbeing. A mutual understanding is part of our relationship and we need to ensure your understanding of our financial agreement.

It is important to know the terms of your health insurance policy. Your policy is a contract between you and your insurance carrier. Patients and/or their conservators/responsible parties are responsible for knowing which providers are participating with their insurance carrier(s).

Participating Insurances: Valid health insurance information must be provided to iMind Mental Health and Wellness to ensure appropriate reimbursement for your care. You will be responsible for any deductible, copay, coinsurance and/or non-covered service.
Non-Participating Insurances: Valid health insurance information must be provided to us to verify if your policy has "out of network" benefits. You will be responsible for any deductible, copay, coinsurance and/or non-covered service.
Secondary Insurance: As a courtesy, we will bill your secondary insurance. Valid health insurance information must be provided to ensure appropriate billing.
Medicare: As a participating provider of Medicare Part B, iMind Mental Health and Wellness will bill Medicare Part B for eligible services.

______ (initial) I agree to be financially responsible for payment of iMind Mental Health and Wellness's services. Cash, check and credit cards are accepted.
______ (initial) Current insurance cards must be presented at every office visit. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt.
______ (initial) I agree to give iMind Mental Health and Wellness my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers if needed. I understand that if I fail to give complete and accurate information about my insurance benefits, this may result in a denial of my claim or delay in payment. I agree to pay iMind Mental Health and Wellness the balance on my account after my insurance claim has processed.
______ (initial) I agree that if my insurance requires me to provide a referral and if the referral is not in place before my appointment, I will pay in advance an estimate of charges for my office visit or reschedule my appointment.
______ (initial) I understand that I will be responsible for any fees associated with missed appointments or any cancelled appointments in which a 24-hour notice was not given.
______(initial) I understand there will be a $25.00 fee for all returned checks.
______(initial) I agree to pay copays and deductibles at the time of service unless prior arrangements have been made.

______(initial) I agree to pay any balance remaining on my account upon receipt of a statement and I understand that I must verify my current address at each appointment.
______(initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. I will be responsible for all costs of collection.

I have read and understand iMind Mental Health and Wellness's financial policies and I accept responsibility for the payment and fees associated with my care.

Signature	**Date**

Assignment of Benefits

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to iMind Mental Health and Wellness. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS.** This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original.

I authorize the release of any medial information necessary in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me.

I have read and understand iMind Mental Health and Wellness's financial policies and I accept responsibility for the payment and fees associated with my care.

Signature	**Date**