



Credit Card Policy

At The Remedy Mental Health, our goal is to make your billing experience as simple and efficient as possible. To ensure a smooth check-in process and reduce administrative delays, all patients are required to provide a valid credit, debit, HSA/FSA card to keep on file.

Please bring the card you would like to keep on file, to your first appointment.

All payments are managed through our HIPAA-compliant, secure practice management system, which uses a PCI DSS (Payment Card Industry Data Security Standard) compliant processing system. Your card information is encrypted and stored on their secure servers.

The Remedy office staff do not have access to your full card number; only the last four digits are visible for verification.

Your card on file will be used to pay for, copay, coinsurance, deductibles, outstanding balances after insurance processing.

After your insurance processes your claim, they will send you an Explanation of Benefits (EOB) showing what portion of the bill is your responsibility. If you have questions about your patient responsibility, please contact your insurance company before charges are applied.

Patient Acknowledgment

By signing below, I acknowledge that:

- I will provide a valid credit/debit card to The Remedy Mental Health at my first appointment or initial visit.
- All copays are due at time of service and will be charged to the card we have on file unless you choose to use another form of payment. This also applies to anyone who is not using insurance at their appointment and/or is self-pay.
- I authorize The Remedy Mental Health to charge my card for copays, deductibles, and outstanding balances.
- If my card expires or becomes invalid, I will provide updated payment information promptly.
- Any credit balance on my account after insurance adjustment will be refunded to the same card on file, if possible. Otherwise check or ACH transactions will be provided as refund options.
- I understand that I am ultimately responsible for any charges that are not covered by my insurance plan(s).

Patient Name: _____ **Date:** _____

Signature: _____