

Financial Policy

Thank you for choosing The Remedy Mental Health for your care. We are committed to helping you understand the financial responsibilities associated with your treatment.

Please review this policy carefully. By signing below, you acknowledge that you understand and agree to the payment, insurance, cancellation, and account requirements described in this document.

Financial Responsibility

- You are responsible for payment for all services you receive from The Remedy Mental Health, including any amounts not paid by insurance.
- Self-pay payments are due in full at the time of service.
- Insurance co-pays are due at the time of service.
- You are responsible for deductibles, co-insurance, non-covered services, denied claims, and any remaining balance not paid by your insurance plan.
- Payment is expected regardless of whether another person, insurance company, or other third party is responsible for all or part of your bill.
- You must provide accurate and current insurance and billing information. Please notify us promptly if your insurance coverage changes.
- All required registration forms must be completed before you may see a clinician.

We accept cash, checks, credit cards, debit cards, and CareCredit.

Adult patients: Adult patients are responsible for full payment of any co-pays and self-pay rates at time of service.

Minor patients: Parents or guardians accompanying minors are responsible for payment of any co-pays and self-pay rates at the time of service. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges may be pre-authorized to an approved credit plan or credit card, or paid by cash, debit card, or check at the time of service.

Insurance Coverage and Billing

Your insurance policy is a contract between you and your insurance company. The Remedy Mental Health is not a party to that contract and cannot guarantee that your insurance company will pay for your services.



Phone: (952) 431-5330
Fax: (952) 431- 5334
3535 Vadnais Center Dr., Suite 150
Vadnais Heights, MN 55110

Although The Remedy Mental Health may be listed as an in-network provider, this does not guarantee coverage, payment, or authorization for a specific service.

By providing your insurance information, you authorize The Remedy Mental Health to submit claims to your insurance company and, when applicable, accept assignment of insurance benefits.

Please understand the following:

- We cannot bill your insurance company unless you provide complete and accurate insurance information.
- You are responsible for understanding your insurance benefits, including co-pays, deductibles, co-insurance, prior authorization requirements, exclusions, and non-covered services.
- Some or all services you receive may not be covered or considered medically necessary by your insurance plan.
- If your insurance company denies or rejects a claim, you are responsible for the balance unless the denial resulted from an error by The Remedy Mental Health.
- If your insurance company has not paid a claim within 60 days, the unpaid balance may be transferred to your responsibility.
- You are responsible for notifying us when your insurance coverage changes. If your new insurance plan does not include The Remedy Mental Health as a participating provider, you may be responsible for the full cost of your services.
- You should contact your insurance company or employer directly with questions about your benefits or coverage.

Employee Assistance Programs

You must notify us before your first appointment if you intend to use an Employee Assistance Program, or EAP, benefit.

Once a service has been submitted to or billed through your health insurance plan, we will not rebill that service to an EAP.

Past-Due Balances and Service Charges

- A monthly finance charge of 1.5% may be applied to balances that remain unpaid for more than 30 days.
- Past-due accounts may be referred to a collection agency.
- A \$25 service charge will be applied to returned checks.

- Reasonable billing and collection activities related to an unpaid account will not be considered a breach of confidentiality when permitted by law.

Please contact us promptly if you have questions about your balance or need to discuss payment arrangements.

Acknowledgment of Financial Responsibility

To the best of my knowledge, the information I have provided is accurate and complete.

I understand that I am financially responsible for all services provided to me or to the patient for whom I am the responsible party. This includes co-pays, deductibles, co-insurance, self-pay charges, non-covered services, denied claims, and any other amounts not paid by an insurance company or other third party.

I agree to pay all amounts for which I am responsible in a timely manner and to make appropriate payment arrangements when necessary.

A photocopy or electronic copy of this authorization will be considered as valid as the original.

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made directly to The Remedy Mental Health for services provided to me by its clinicians.

Release of Information and Assignment of Benefits

I authorize The Remedy Mental Health to disclose the portions of the patient's medical or financial records that are reasonably necessary to obtain payment, process insurance claims, determine benefits, or collect amounts due. Information may be disclosed to insurance carriers, benefit plans, government programs, or other parties that may be responsible for payment, as permitted by law.

I assign to The Remedy Mental Health any insurance or other health care benefits payable for services provided to the patient. These benefits may be applied directly to the patient's account.

I also authorize The Remedy Mental Health and its representatives to submit, correct, appeal, or otherwise manage claims on the patient's behalf with any person, organization, insurance company, or benefit program that may be responsible for payment.



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I acknowledge that I have read, understand, and agree with the above document.

Patient Name (Print): _____

Patient/ Guardian Signature: _____

Relationship to Patient (if not the patient) _____

Date: _____