Open Arm
Mental Health

NORTHWEST OPEN ARM MENTAL HEALTH

PATIENT FINANCIAL RESPONSIBILITY AND PAYMENT CONSENT FORM

1. Patient Information

Patient Full Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Email: _____

Responsible Party (if different): _____ Relationship: _____

Insurance carrier: _____ Member ID: _____ Group #: _____

2. Services Provided

I understand that Northwest Open Arm Mental Health provides outpatient psychiatric and mental health services, which may include:

- Initial psychiatric evaluations and diagnostic assessments
- Psychiatric medication management
- Comprehensive psychiatric evaluation and ongoing medication management
- Psychiatric therapy
- Medication-assisted treatment
- ADHD assessments and treatment
- Mental health follow-up appointments
- Patient education and information on community resources
- Telehealth and virtual psychiatric services
- Medication monitoring and treatment planning
- Other clinically appropriate mental health services

3. Financial Responsibility

I understand that I am financially responsible for services provided. I agree to:

- Pay applicable copayments, deductibles, coinsurance, and other patient responsibilities
- Pay for services not covered by my health insurance
- Provide accurate and current insurance and billing information
- Notify the clinic of changes to my insurance coverage
- Pay outstanding balances within the payment period established by the clinic

I understand that insurance verification does not guarantee payment or coverage.

4. Insurance Billing, Assignment of Benefits, and Release of Information

I authorize Northwest Open Arm Mental Health to submit claims to my insurance plan and to receive payment directly from my plan for covered services (assignment of benefits). I authorize the release of the information needed to process claims, including diagnosis, dates of service, and procedure codes, to my insurance plan and its agents. I understand that this information is limited to what is needed for payment.

5. Self-Pay and Uninsured Patients

Patients without insurance coverage or those choosing not to use insurance agree to pay the established self-pay rate for services received. The clinic will provide a Good Faith Estimate of expected charges before scheduled services, as required by federal law. For patients who choose not to submit claims to insurance, applicable federal and state requirements will be followed.

Current self-pay rates: Initial evaluation $_____ Follow-up visit $_____ Other: _____

6. Payment Methods

Northwest Open Arm Mental Health may accept: ☐ Credit Card ☐ Debit Card ☐ Electronic Payment Portal ☐ Other: _____

Storing a card for future charges requires a separate signed card-on-file authorization.

7. Missed Appointments and Cancellations

I understand that appointments require advance scheduling and that missed appointments may affect access to care. I understand that I must give at least ____ hours' notice to cancel or reschedule. A late-cancellation or missed-appointment fee of $_____ may apply, will be disclosed to me in advance, and is applied only in accordance with applicable law and the clinic's written policy. Insurance does not pay these fees.

8. Outstanding Balances

I understand that I am responsible for resolving outstanding balances for services provided. The clinic may provide billing statements, payment reminders, and opportunities to discuss payment arrangements. Any collection activity will be handled in accordance with applicable federal and state laws, and the clinic will notify me before any account is referred for collection. Financial concerns will be addressed separately from clinical decisions regarding my treatment and safety.

9. Refunds and Billing Questions

I understand that I may contact Northwest Open Arm Mental Health at 763-703-6686 regarding billing questions, payment discrepancies, or refund requests. Any refunds or billing adjustments will be reviewed according to clinic policy and applicable payer requirements.

10. Patient Authorization and Acknowledgment

By signing below, I acknowledge that I have reviewed and understand the financial responsibilities described in this document, have had an opportunity to ask questions, understand that I am responsible for applicable charges, authorize the clinic to bill my insurance when applicable, and agree to pay applicable patient balances in accordance with the clinic's payment policies.

Patient Signature

Patient Full Name: _____ Date: _____ Time: _____

Patient Signature: _____

Responsible Party / Guarantor (if applicable)

Name: _____ Relationship: _____

Signature: _____ Date: _____

Clinic Representative

Staff / Provider Name: _____ Signature: _____

Date: _____

This form does not replace a separate credit/debit card authorization or any legally required financial disclosure.