Self- Pay Agreement

First Name	Last Name	M.I.	Date of Birth

The Self-Pay Agreement is intended to provide self-paying patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Conventions Psychiatry & Counseling. The patient/legal guardian will be responsible for full payment of charges at the time of services.

The patient has been registered as self-pay due to the following reasons marked below:

_____ The patient/legal guardian does not have insurance coverage.

OR

_____ The provider performing services or therapies is not a participating provider with my health insurance. Therefore, these services/therapies are not covered by my policy.

_____ The scope of services rendered by this provider may not be covered by my health insurance policy.

_____ The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician.

_____ No claim will be sent to my insurance since it is my personal decision not to use my health insurance benefits for the above services/therapies even though I understand that these services/therapies are considered covered by my policy.

Conventions will not bill any insurance plan at a later date if the Patient/Legal Guardian elects to be self-pay at the time of service.

My signature below acknowledges receipt of the Self-Pay Agreement.

_____

Patient/Legal Guardian Signature Date

Self-Pay Agreement explained by:

_____

Staff Name (Print) Date