

**ACKNOWLEDGMENT OF SELF–PAY STATUS**

**Patient Name:**

**DOB:**

**Dear Patient,**

You are being provided this letter of acknowledgement because you have requested that your doctor visit today be coded as “self-pay”. A self-pay option is offered to patients who elect to pay for the service in full on the date of service and who will not be submitting the claim to an insurance carrier.

**You have requested that this service be coded as self-pay because (initial one):**

\_\_\_\_ You have no health insurance.

\_\_\_\_ You have health insurance but you do not want your insurance billed and instead want to pay out of pocket.

\_\_\_\_ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We want you to know what to expect so that you can make an informed decision. In order to**

**accomplish this, by signing below you agree to the following:**

• All fees for the self-pay service must be paid on the date of service.

• The self-pay amount covers only the professional services provided by your provider. You

are financially responsible for all ancillary services, for example laboratory, prescription medication, imaging or other services not performed by your provider. You will receive a separate bill from those other providers for their services.

• Please let your provider or a staff member know where you prefer to have your lab work or imaging done. We will gladly provide you the paperwork you will need to accomplish this.

• If you have insurance or other types of coverage, services received today that are included in the “self-pay” option will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay option.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient’s duly authorized representative.

**Patient / Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**-NOT PART OF THE LEGAL MEDICAL RECORD-**