



Self-Pay Patient Form

This form outlines the payment policies at Bee Well Pediatrics for patients who choose to pay for their healthcare services without the aid of health insurance. It's important to understand these policies to ensure smooth financial interactions and to clarify the methods and terms of payment.

Self-Pay Policy

- **Payment Responsibility:** All self-pay patients are required to pay for services rendered at the time of their visit. Acceptable forms of payment include cash, credit cards, and debit cards. **Please note: Checks are not accepted.**
- **Payment Options:** Patients have the right to choose self-pay for services even if they have insurance coverage. Bee Well Pediatrics complies with legal requirements allowing patients this choice. However, patients must sign a waiver acknowledging they are opting for self-pay instead of using their insurance benefits. This waiver ensures patients understand that Bee Well Pediatrics will not submit a claim to their insurance for these services.
- **Estimates:** An estimate of the expected charges will be provided based on the services scheduled for your visit. Please be aware that additional charges may apply if further services or treatments are necessary.
- **Discounts:** A discount is available for self-pay patients who pay the full amount at the time of service. Please contact our front desk for information regarding current discount rates.

Payment Plan Options

- **Eligibility for Payment Plans:** Payment plans are only available for services where the total cost exceeds \$1,000. This policy is in place to manage the administrative aspects efficiently while still accommodating patients facing larger medical bills.
- **Plan Setup:** Eligible patients who wish to utilize a payment plan must set up this arrangement prior to receiving services. A minimum deposit may be required, depending on the total cost.
- **Terms:** The specifics of each payment plan, including monthly payment amounts, the total number of payments, and due dates, will be outlined in a written agreement.

Refund Policy

- **Overpayments:** Any overpayments identified will be refunded within 30 days.
- **Service Cancellation:** Full refunds will be issued for prepayments if services are canceled in accordance with our cancellation policy.

Acknowledgement and Agreement: I have read and understood the self-pay policies of Bee Well Pediatrics. I agree to adhere to these policies and accept responsibility for payment as outlined.

Patient Name: _____ Parent or Guardian Name: _____

Signature: _____ Date: _____