Self-Pay Patient Disclosure/ Decision

I have reviewed and made the following decision:

[ ] *I currently do not have any active insurance coverage for today's office visit.*

[ ] *I currently have active insurance coverage BUT according to the benefits of the current plan, the reason for my office visit today is considered "non-covered" so I am requesting to be seen as a Self-Pay patient today* ***with discount given for services provided/ordered.*** *I agree to be financially responsible for charges accrued today & pay in full at Time of Service in order to receive the discount. I also acknowledge that I will receive a receipt for payment today but no other written breakdown of the charges for the services provided.* **NOTE: Do Not Recommend using HSA/FSA card(s) as payment for this reason.**

[ ] *I currently have active insurance coverage but am requesting to be seen as a Self-Pay patient today for which I will be financially responsible with* ***no discount given for services****. If I choose to submit these charges for reimbursement, this will be my responsibility and I will need to contact the insurance carrier to determine the specific requirements to do so. I understand that Pediatric & Adolescent Specialists of Rockwall* ***will not*** *file any claim for these services and that I cannot request this be done at a later date.*

I understand & agree that payment for these services will be required at the end of the visit upon check-out.

I wish to obtain services from Pediatric & Adolescent Specialists of Rockwall. I acknowledge that a copy of this form can be provided upon request.

_____ _____

Print Patient Name DOB

_____ _____

Patient/Guarantor Signature Date

I certify that I have reviewed this form with the patient and that the patient has acknowledged the information contained in this form and was provided a copy for the patient's records, if requested.

_____ _____

Witness Signature Date

8/8/19 /alr