

# FISHERS LANDING PRIMARY CARE | PRIVATE PAY AGREEMENT

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PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

## PURPOSE OF THIS AGREEMENT

This document serves as a formal acknowledgment that I, the undersigned patient (or legal representative), am electing to receive medical care and services from the above-named clinic on a self-pay basis, and that I fully understand and accept the associated terms and financial responsibilities.

## TERMS

### 1. Self-Pay Status

I acknowledge that I am receiving care as a self-pay patient and that no portion of today's visit or any future visit under this status will be submitted to any insurance carrier, including but not limited to Medicaid/Apple Health (e.g., Molina), Medicare, or any commercial health insurance plan.

Initial: \_\_\_\_\_

### 2. Payment Due at Time of Service

I understand and agree that full payment is due at the time of check-in, prior to receiving services. Failure to remit payment may result in a cancellation or delay of services.

Initial: \_\_\_\_\_

### 3. No Submission to Insurance / No Reimbursement Guarantee

I acknowledge that the clinic will not submit any claims to insurance on my behalf. I understand that there is no guarantee I will be reimbursed for any amount paid, even if I choose to submit documentation to my insurance independently.

I further acknowledge that certain plans, including but not limited to Medicaid/Apple Health, do not permit reimbursement for out-of-network or self-pay services, and that I assume all risk and responsibility for such costs.

Initial: \_\_\_\_\_

### 4. Responsibility for Ancillary Services

I understand that if my provider orders or recommends additional services such as laboratory testing, diagnostic imaging, prescriptions, specialist referrals, or procedures performed outside of this clinic, those services may be billed by third-party providers and are not included in **this** self-pay agreement between myself and Fishers Landing Primary Care.

I acknowledge and agree that it is entirely my responsibility to verify whether any third-party providers or facilities accept my insurance plan, and to obtain any required authorizations or referrals. Fishers Landing Primary Care and its staff are not responsible for determining coverage, verifying insurance participation, or confirming network status for outside services. I further acknowledge that the clinic will not be liable for any costs I incur from third-party providers or facilities, regardless of whether those providers accept or deny my insurance.

Initial: \_\_\_\_\_

**5. Acknowledgment of Cash Pricing**

I understand that the clinic has established cash pricing for self-pay patients, which may vary over time and are subject to change. I have been provided a current fee schedule for common services and understand that fees not listed will be communicated prior to service whenever reasonably possible.

Initial: \_\_\_\_\_

**Cash Pay Pricing (Subject to Change)**

SERVICE TYPE	CASH PAY PRICING (USD)
NEW PATIENT VISIT	\$250
ESTABLISHED OFFICE VISIT	\$150
PHYSICAL EXAM (ANNUAL WELLNESS) <b>Under Age of 40</b>	\$200
PHYSICAL EXAM (ANNUAL WELLNESS) <b>Over Age of 40</b>	\$250
EKG (ELECTROCARDIOGRAM)	\$60
TESTOSTERONE INJECTION (PT PROVIDES RX)	\$25
DEPO INJECTION (PT PROVIDES RX)	\$25
TORADOL INJECTION	\$45
B12 INJECTION (PT PROVIDES RX)	\$30
FLU SHOT	\$60
UA (Urine Analysis)	\$20
CANCELLATION FEE (LESS THAN 24 HRS)	\$75

***\*Pricing applies exclusively to office visit services provided by Fishers Landing Primary Care. Laboratory tests, imaging, and prescriptions are billed separately by independent third-party providers and may involve additional costs. Patients are solely responsible for verifying pricing with any external providers.***

**Patient Acknowledgment**

By signing below, I confirm that I:

Have read and understand the terms of this private pay agreement;

Understand that I am choosing to pay out-of-pocket and that no insurance will be billed;

Agree to pay in full at check-in;

Have been given the opportunity to ask questions and receive answers.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_