Self Pay Agreement

Client Name: _____ DOB: _____

After reviewing my insurance benefits with _____,
I have elected to **NOT** utilize my insurance benefits.

I agree to pay the agreed upon fee out-of-pocket of _____.
I understand that my insurance will not be billed and my fee will not go towards my deductible.

This authorization is valid from the date of my/my guardian's signature below and shall expire upon the date on which I deliver written notice of termination to the provider. This authorization may be canceled in writing at any time.

If I choose to utilize my insurance benefits in the future, I agree to deliver written notice of my request to my provider that will take in effect on the date that my notice is signed.

Client Signature: _____ Date: _____

Provider Signature:_____ Date:_____