PATIENT ELECTION TO SELF-PAY FOR SERVICES

I,_____, the undersigned patient, acknowledge that I understand and agree that:

1. Lifespan Mental Health, PLLC **("Clinic")** is a participating provider with **("Insurance Company")**.

2. I am covered by one of the **Insurance Company** health insurance plans.

3. The health plan under which I am covered includes benefits for some or all of the services provided by **Clinic**.

4. Despite the above, I do not wish **Clinic** to submit a claim to **Insurance Company** for services provided to me by **Clinic**.

5. Until such time as I may otherwise advise **Clinic** in writing, I elect to pay for all services I receive from **Clinic** at their self-pay rates.

6. By election to self-pay for services, any payments I make to **Clinic** will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with **Company** unless otherwise permitted under the terms of my health plan.

7. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

8. I have freely chosen to self-pay for services after having asked **Clinic** about payment options and having carefully considered those options.

Date:_____ Patient: _____

Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

_____

Printed Name of Patient or Responsible Party

_____

Capacity of Responsible Party (e.g. parent, guardian, etc.)