Election to Self-Pay Agreement

The following is a financial agreement between the Patient and Family Psychiatry of The Woodlands that states the rights and financial responsibilities for Electing to Self-Pay:

I will be paying for my services directly because I have chosen to opt out of utilizing my existing medical insurance coverage for this service. **I understand that by choosing this option I forgo the ability to submit a claim directly to my medical insurance provider for the service.** I also understand that Family Psychiatry of The Woodlands will not retroactively submit a claim to an insurance provider for services rendered.

I understand, as a self-pay patient that I must pay the charges credit card, in full, prior to the scheduled appointment time.

As a self-pay patient, I have the right to request that any medical records generated as result of today's visit NOT be disclosed to present or future medical insurance plan(s). (**Please initial one**):

_____ Family Psychiatry of The Woodlands may share my medical record/treatment with my health insurance plan.

_____ Family Psychiatry of The Woodlands may not share my medical record/ treatment with my health insurance plan.

By signing below, I confirm that I understand the terms of this agreement and understand that I am completely responsible for any and all costs associated for all services provided to me, my dependents, or any other person for whom I have assumed financial liability.

Patient Name (Printed): ______________________________________ DOB: ______________

Printed Name of Responsible Party: _____________________________

(If patient is a minor or unable to sign for him/herself)

Signature of Patient/Responsible Party: __________________________ Date: ______________

Relationship to Patient: _______________________________________

For Office Staff Only:

Date of Appointment: ____________________ Provider: _____________________

Payment Received: ____________________ Received by (Initial): ____________