SELF-PAY PATIENT AGREEMENT

I, ____, hereby acknowledge that at this time, my family and I are without medical health insurance coverage and, as such, I hereby agree to be personally responsible for the payment of medical services that are provided to me, my spouse and minor children. I further agree to the following:

1. I will provide my physician with the upfront payment as instructed, to be paid when I (or my spouse and minor children) present to the check in window prior to the appointment with the physician.

2. I am aware that the upfront payment may not pay the balance in full for services provided on the date of service; it is only an upfront payment.

3. Because my family and I are without medical health insurance coverage and I am personally responsible for the payment of medical services rendered to me, my spouse and minor children; I acknowledge that I may be eligible to receive a forty percent (40%) reduction in the charges for medical services rendered to me, my spouse and any minor children.

4. Following any reductions in the charges for medical services provided, I agree if I cannot pay them in full on the date services are rendered, I will pay within thirty (30) days of the date services are rendered or make alternative arrangements for the collection of such debt with the office manager or central billing office of the practice.

5. I acknowledge that failure on my part to adhere to the aforementioned may result in my account being sent to an outside collection agency.

______________________________	____________________
PATIENT NAME	DOB
______________________________	____________________
PATIENT SIGNATURE	DATE