Self-Pay Agreement

I, _____ (client name), am signing this agreement to indicate that I am seeking treatment with provider _____ (provider name) and to attest that I understand my treatment, starting on _____ (date), will not be covered by insurance because:

____ I am not aware of any insurance coverage for the services I am seeking. *If it turns out at a later date that I do have coverage, this waives any future right to be reimbursed by my insurance plan for services that have already been provided if the therapist is a network provider for my plan*

____ I am currently covered by insurance, but I am choosing not to use this coverage for my treatment. In doing so, I understand that I will not get the benefit of any provider discounts, including during any deductible period, and understand that my provider is not obligated to bill the plan. *I understand that in doing so I waive any future right to be reimbursed by my insurance plan for services that have already been provided.*

____ I have been notified by my provider or by an insurance plan representative that my treatment will not be paid for by my health plan because it:

- ____ is not a covered benefit under my benefit plan
- ____ is not/ no longer covered by my benefit plan because it does not meet the plan's medical necessity standards
- ____ is no longer covered -- my benefits for this service has been exhausted or terminated

____ While some of the treatment I desire is covered by my insurance plan, some is not, and I am willing to pay for the additional treatment (ex. extended sessions, phone or video sessions)

_____ Extended session agreement: I understand that insurance typically covers only one 45 minute session per day. Because of this, I am aware that my therapist will bill my insurance plan for one 45 minute session per day only. The charge for any additional time PLUS any copayments or deductibles from the first 45 minutes will be my responsibility and payable at the session. If the therapist is not a provider for my plan, I understand I will be expected to pay in full for the extended session, and that, if desired, I will be given an invoice for the first 45 minutes of the session so I can seek reimbursement from my insurance plan.

____ other:_____

If this is the result of a decision by my health plan, I have been informed about the reason, am aware of my plan's appeal process, have elected not to appeal, or am in the process of appealing this decision. In the meantime/instead I elect to continue therapy on an out-of-pocket basis, and understand I will not be reimbursed by my insurance unless I am successful on appeal.

I have chosen to begin/continue treatment with my provider on a self-pay basis starting _____(date), which is no earlier than the date I have signed this form. I agree that the provider may collect charges for the proposed services at his/her full fee-for-service rate, or at the rates outlined below.

$_____(amount) for _____(service description)
$_____(amount) for _____(service description)
$_____(amount) for _____(service description)
$_____(amount) for _____(service description)

I understand that insurance plan maximums that apply to medically necessary covered services will not apply and will not limit the amount I may become obligated to pay for the proposed services.

I understand that I have a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. *I understand that in signing this I waive any future right to be reimbursed by my insurance plan for services that have already been provided.*

I have read and understand this agreement. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by the provider.

_____ _____
Signature of participant Date

_____ _____
Signature of witness Date