

# PATIENT ELECTION TO SELF-PAY FOR SERVICES

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

1. Provider with Diligence Care Plus is a participating provider with my insurance plan (name of insurance carrier/company) .....
2. I am covered by one of (name of insurance) ..... health insurance plans. **NOTE:** Patient who have Medicare can not use this form.
3. The health plan under which I am covered includes benefits for some or all the services provided by Diligence Care Plus
4. Despite the above, I do **NOT** wish Diligence Care Plus to submit a claim to my insurance carrier for services provided to me by Diligence Care Plus.
5. Until such time as I may otherwise advise Diligence Care Plus in writing, I elect to pay for all services I receive from Diligence Care Plus at their cash price or discounted rates.
6. By election to self-pay for services, any payments I make to Diligence Care Plus will not be credited toward satisfying any deductible or copay I may be subject to under my health insurance plan 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 Diligence Care Plus about payment options and having carefully considered those options.
9. I do NOT have **Medicare** as my insurance carrier/health plan (initial here) .....

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/Relationship