

REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES

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

1. I previously signed a Patient Election To Self-Pay For Services on (date signed)
2. I continue to be insured under a health insurance plan offered by (name of insurance carrier/health plan with which Diligence Care Plus continues to participate.
3. By my signature below, I revoke my earlier election to self-pay for services and direct Diligence Care Plus to begin billing my health plan for services provided by Diligence Care Plus.
4. The health plan under which I am covered may limit coverage for services provided by Diligence Care Plus and/or may subject me to a deductible that must be satisfied before any benefits are provided under the health plan.
5. I will be personally responsible for the cost of any services provided to me by Diligence Care Plus that are not covered by my health plan to the extent consistent with the terms of my health plan.
6. Diligence will bill for services at their contracted rates as a participating provider with my insurance company which may be higher than the Self-pay or discounted rate Diligence Care Plus makes available to patients who self-pay for services.
7. I have read this Revocation of Patient Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about this form. Any questions I may have had about this form have been answered to my satisfaction.

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