Acknowledgement of Self-Pay Status – Patient Responsibility

Patient Name: _____ Account: _____

Dear Star Patient,

You are being provided this letter of acknowledgement because you have requested that your visit today be coded as "self-pay." Self-pay patients are those who are uninsured or who elect not to submit the claim to an insurance carrier. You have requested this service be coded as a self-pay because **(select one):**

- ○ **You have no health insurance.**
- ○ **You have health insurance but do not want your insurance billed for this date of service and instead want to pay out of pocket.**
- ○ **You have been told about the sliding fee scale and have declined to participate**

We want you to know what to expect so that you can make an informed decision. To accomplish this, by signing below you agree to the following:

- An estimate has been provided to you at our self-pay discounted rate. The estimated patient responsibility is due and should be paid in full today.
- If you have insurance or other types of coverage, services received today that are included in the "self-pay" discount will not be reimbursed by your carrier nor applied to your deductible. You may want to discuss with your insurance carrier before agreeing to the self-pay discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient or Representative Signature: _____ Date:_____

If signed by someone other than the patient, please specify relationship to patient:_____

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