Name: _____ DOB: _____

ACKNOWLEDGMENT OF SELF–PAY STATUS
PATIENT RESPONSIBILITY

Podiatry Services
24640 Jefferson Ave, Ste 109
Murrieta, CA 92562
O: 951.677.1323
F: 951.239.4233

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your doctor visit today be coded as "cash/self-pay." Patients who elect to pay for the service in full on the date of service will not be submitting the claim to an insurance carrier. You have requested that this service be coded as self-pay because (**initial one**):

____ You have no health insurance, or you do not have a current authorization from your insurance and/or medical group.

____ You have health insurance but you do not want your insurance billed and instead want to pay out of pocket.

____ Other (please explain): _____

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

- All fees for the self-pay service must be paid on the date of service.
- The self-pay amount covers only the professional services provided by your doctor. You are financially responsible for all ancillary services, for example laboratory, x-ray or other services not performed by your doctor. You will receive a separate bill from the outside facilities for those non-physician services. If you choose to use another laboratory or x-ray facility it will be your responsibility to obtain your test results and provide the results to our office.
- You will not receive a refund or credit for services rendered, if you decide at a later time to bill your insurance. Retro-authorizations will not be accepted after services are rendered.
- If you have insurance or other types of coverage, services received today that are included in the "cash/self-pay" discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this 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 _____ Time_____

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

Interpreter Signature _____ ID # _____ Date _____ Time_____