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# SELF-PAY AGREEMENT

**Member/Client Name:** _____ **Date of Birth:** _____

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

_____ I have no insurance coverage/I am not aware of any insurance coverage for the services I am seeking. *If it turns out at a later date that I did have coverage, I waive any future right to be reimbursed by my insurance plan for services that have already been provided.*

_____ I am currently covered by insurance, but I am choosing not to use this coverage for my treatment. In doing so, I understand that my provider will not be billing the insurance 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 my health plan that my therapy will not be covered by my plan because:

___ it is not a covered benefit under my benefit plan
___ it is not covered by my plan because it does not meet the plan's medical necessity standards
___ my benefits for this service have been exhausted or terminated
___ other: _____

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

___ Extended session agreement: I understand that insurance typically covers only one 50-minute couples/family session per day, or one 45- or 60-minute individual session per day, depending on the plan. Because of this, I am aware that my therapist is able to bill my insurance plan only for this time period per day. If my therapist is a provider for my insurance plan, I understand that it will be my responsibility to pay for the copayments or deductibles for the part of the session that will be billed to the insurance PLUS the total cost for any additiona time I desire beyond that session. If the therapist is NOT a provider for my plan, I understand I will be expected to pay in full for the entire extended session, and if I wish to seek reimbursement from my health plan, I understand I will be given an invoice that reflects only covered portion of the session, i.e. the 45- or 60-minute individual session or 50 minutes couple session.

_____ Other:_____

*If this is the result of a decision by my plan, I have been informed about the reason, and am aware of the appeal process at my plan and through my State Department of Insurance or Managed Health Care. I have elected not to appeal or am in the process of appealing this decision. In the meantime/instead, I choose to continue treatment and pay out of pocket, understanding I will not be reimbursed by my plan 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 below.** I agree that the provider may collect charges for the proposed services at the rates outlined below:

| Description of Service to be Provided | Approximate Cost |
|---|---|
| | |
| | |
| | |

I understand 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 client Date