INTERMED
Care without compromise.

ACKNOWLEDGMENT OF SELF-PAY STATUS
PATIENT RESPONSIBILITY

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your doctor visit/service today be coded as “self-pay” and that you receive a “self-pay discount”. A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and who will not be submitting the claim to an insurance carrier. For this service to be coded as self-pay, please initial and provide Date of Service.

_____ I have health insurance, but I do not want my insurance billed and instead want to pay out of pocket for this service.

Date of Service: _____

We want you to know what to expect so that you can make an informed decision. 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 services provided by your InterMed physician for the date listed above. You may receive a separate bill from a non InterMed provider, i.e., another provider that reads and interprets an x-ray as these services are not covered under this agreement.
- If you have insurance or other types of coverage, services received today that are included in the “self-pay” discount will not be submitted or 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. The charges for this date of service are an estimate until final coding of the claim and additional charges may be sent for this date of service. I confirm that I am the patient, or the patient’s duly representative.

Patient or Representative Signature:_____ Date:_____

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

-NOT PART OF THE LEGAL MEDICAL RECORD-