



## **PATIENT ELECTION TO SELF-PAY FOR SERVICES**

**I, The undersigned patient, acknowledge that I understand and agree to the following:**

- MindSet Solutions and Wellness Center, LLC (“Clinic”) is a participating provider in the health insurance plan under which I am covered.
- The health plan under which I am covered includes benefits for some or all of the services provided by Clinic.
- Despite the above, I do not wish Clinic to submit a claim to my health insurance plan for services provided to me by Clinic.
- Until such time as I may otherwise advise Clinic in writing, I elect to pay for all services I receive from Clinic at their Self-Pay patient rates.

➤ By election to self-pay for services, any payments I make to Clinic will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with Company unless otherwise permitted under the terms of my health plan.

➤ I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

➤ I have freely chosen to self-pay for services after having asked Clinic about payment options and having carefully considered those options.

➤ I agree that a photocopy or electronic copy of this form shall be considered as valid as the original.

➤ Expiration: This election to self-pay for services will expire 60 days after the date of closure of care and discharge from MindSet Solutions and Wellness Center, LLC OR when the client rescinds this election, whichever is sooner.

➤ If applicable, I attest that I am the legal guardian and have the right to consent on behalf of this minor.

Signature of Client or Legal Guardian : \_\_\_\_\_

Printed Name : \_\_\_\_\_

Date : \_\_\_\_\_