REGIONAL HEART SPECIALISTS
Patient Centered Care

ACKNOWLEDGEMENT OF SELF-PAY STATUS
PATIENT RESPONSIBILITY

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your doctor visit 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. You have requested that this service be coded as self-pay because **(initial one):**

____ You have no health insurance.

____ 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. 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 physician. You are financially responsible for all ancillary services, for example echocardiogram, holter monitor, or other services rendered at Regional Heart Specialists. You will receive a separate bill from the Regional Heart Specialists Billing Department for those non-physician services.
- Please let your physician or a staff member know if you prefer to have your lab work or echocardiogram done by a different facility. We will gladly provide you with the paperwork you will need to accomplish this.
- If you have insurance or other types of coverage, services received today that are included in the "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 _____

Printed Name _____ Date _____

-NOT PART OF THE LEGAL MEDICAL RECORD-