CLIENT ELECTION TO SELF-PAY FOR SERVICES

I, ________________________________, the undersigned client, acknowledge that I understand and agree that:

1. Becoming Free Counseling Services is a participating provider with __________________________.
2. I am covered by __________________________ insurance plan.
3. Despite the above, I do not wish Becoming Free Counseling Services to submit a claim to my insurance company for services provided to me by Becoming Free Counseling Services.
4. Until such time as I may otherwise advise Becoming Free Counseling Services in writing, I elect to pay for all services I receive from Becoming Free Counseling Services at their out of pocket rate.
5. By election to self-pay for services, any payments I make to Becoming Free Counseling Services will not be credited toward satisfying any deductible I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan.
6. 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.
7. I have freely chosen to self-pay for services after having asked Becoming Free Counseling Services about payment options and having carefully considered those options.

Date: _______________ Signature: ____
Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for themselves.

____
Printed Name of Patient or Responsible Party

____
Capacity of Responsible Party (e.g. parent, guardian, etc.)

REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, ______________________________, the undersigned client, acknowledge that I understand and agree that:

1. I previously signed a Patient Election to Self-Pay for Services on ___________.
   (DATE SIGNED)

2. I continue to be insured under a health insurance plan that Becoming Free Counseling Services continues to participate.

3. By my signature below, I revoke my earlier election to self-pay for services and direct Becoming Free Counseling Services to begin billing my health plan for services provided by Becoming Free Counseling Services.

4. The health plan under which I am covered may limit coverage for services provided by Becoming Free Counseling Services and/or may subject me to a deductible that must be satisfied before any benefits are provided under the health plan.

5. I will be personally responsible for the cost of any services provided to me by Becoming Free Counseling Services that are not covered by my health plan to the extent consistent with the terms of my health plan.

6. Becoming Free Counseling Services will bill for services at their contracted rates as a participating provider with _________________________.

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

Date: ______________ Signature: ____
Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for themselves.

____
Printed Name of Patient or Responsible Party

____
Capacity of Responsible Party (e.g. parent, guardian, etc.)