Self-Pay Form

Patient Full Name: ____________________________________

Date:____________________________________

*Patient/Guardian Initials

_____ Adult patient has no insurance coverage

_____ Minor/Infant patient has no insurance coverage

Select your payment option below:

*Patient/Guardian Initials

_____ Cash Pay Price

I understand that if the Cash Pay Price is chosen, all forms of insurance WILL NOT/CANNOT be billed, nor will the patient be able to submit this to an insurance company for reimbursement.

***Full Name Of The Responsible Party For The Patient**:____

***Date of Birth**: _____/_____/_______ ***Relationship to Patient**: □ Spouse □ Parent □ Other _______________

***Mailing Address**: ______________________________________ **Apt #**: ________

***City**: _______________________ ***State**: _____ ***Zip**: _________ ***Phone** #:(_____)______-________

Print Full Name of Financially Responsible Party: _____________________________________

Signature of Financially Responsible Party: _____________________________________ ***Date**: _________________

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