Rogue Mental Health *Solutions*

15 Crater Lake Ave
Medford, OR 97504
(541) 770-5100

PATIENT ELECTION TO SELF-PAY FOR SERVICES

I,_____ , the undersigned patient, acknowledge that I understand and agree that:

1. _____provider with *Rogue Mental Health Solutions* is a participating provider with _____ (Insurance(s) Company").

2. I am covered by one of the above listed insurance company(s).

3. The health plan under which I am covered includes benefits for some or all of the services provided by *RMHS*.

4. Despite the above, I do not wish for *RMHS* to submit a claim to my insurance(s) for services provided to me by Clinic.

5. Until such time as I may otherwise advise *RMHS* in writing, I elect to pay for all services I received from my provider at RMHS at their self-pay discounted rates.

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

7. I have read and signed *RMHS's Payment Policy* 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.

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

Date: _____
Patient: _____
Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

_____
Printed Name of Patient or Responsible Party

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