

REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, _____, the undersigned patient, 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 offered by _____ ("Insurance Company") with which Lifespan Mental Health PLLC ("Clinic") continues to participate.
3. By my signature below, I revoke my earlier election to self-pay for services and direct Clinic to begin billing my health plan for services provided by Clinic.
4. The health plan under which I am covered may limit coverage for services provided by Clinic 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 Clinic that are not covered by my health plan to the extent consistent with the terms of my health plan.
6. Clinic will bill for services at their contracted rates as a participating provider with Company which may be higher than the self-pay rate Clinic makes available to patients who self-pay for services.
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: _____

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.)