CORNERSTONE HEALTH

Medical ▪ Counseling ▪ Recovery

# Client Election for Self-Pay for Services

◯ No insurance ◯ Yes, I have insurance and do not wish for them to be billed. My insurance company is: _____.

**Please Initial below and sign at the bottom.**

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

_____ Cornerstone Health Counseling may be a participating provider with _____.
Name of Insurance

_____The health plan under which I am covered may or may not include benefits for some or all the services provided by Cornerstone Health Counseling.

_____Despite the above, I do not wish Cornerstone Health Counseling to submit a claim to my insurance for services provided to me by Cornerstone Health Counseling.

_____Until such time as I may otherwise advise Cornerstone Health Counseling in writing, I elect to pay for all services I receive from Cornerstone Health Counseling.

_____By election to self-pay for services, any payments I make to Cornerstone Health Counseling will not be credited toward satisfying any deductible I may be subject to under my health insurance plan.

_____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 this form. Any questions I may have had about this form have been answered to my satisfaction.

_____I have freely chosen to self-pay for services after having asked Cornerstone Health Counseling about payment options and having carefully considered those options.

_____ _____
Signature of patient or responsible party Date

_____
Printed name of client or responsible party