Elective Self-Pay Agreement

Patient Name: ______________________________ Patient DOB: ____ /____ / ____

☐ By checking this box you understand that you are being billed for any services you may receive at Professional Psychiatric Services.

I am agreeing to pay personally out of pocket and electing not to have my insurance billed. I agree to be personally and fully responsible for any and all charges accrued related to the delivery of any services received. I also understand that I may not go back and choose to have a previous session switched from Self Pay to Insurance billed charges.

I understand and agree to the above stated terms. I understand that these sessions/therapies may be considered covered by my insurance policy and filing is done as a courtesy to me, I have chosen to opt out of this option. If I have questions about my bill I can contact the billing department at 513-229-7585 option 6 and talk with a billing representative.

______________________________ ____________________
Signature of Patient/Guardian Date

______________________________ ____________________
Printed Name of Patient/Guardian Date

______________________________ ____________________
Witness Date