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LICENSED MARRIAGE
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SELF-PAY AGREEMENT

I, _____ (client name), am signing this agreement to indicate that I am seeking treatment with provider _____ (provider name), that I understand will not be covered by my health plan, _____ (insurance plan's name). This treatment, starting on _____ (date), will not be paid by my health plan because:

_____ I am choosing not to use my insurance benefits.

_____ The treatment is not a covered benefit under my benefit plan.

_____ Treatment for this service is no longer covered because my plan has determined that treatment does not meet the plan's standard for medical necessity.

_____ It is no longer covered, as my benefits to see this provider for this service have been exhausted or terminated.

_____ Other: _____.

If this is the result of a decision by my health plan, I have been informed about the reason, am aware of my plan's formal clinical appeal process, and have elected not to appeal, or am in the process of appealing this decision. Instead, and/or in the meantime, I have chosen to continue treatment with my provider on a self-pay basis starting _____(date), which is not earlier than the date I have signed this form. I agree to pay the full amount of $_____ (amount) for _____ (services) on an out-of-pocket basis and I understand I will not be reimbursed by my insurance unless I am successful on appeal.

I agree that the provider may bill and collect charges for the proposed services at his/her full fee-for-service rate, or at the rate of $_____per session. Plan provider discounts and the plan maximum that applies to medically necessary covered services will not apply and will not limit the amount I may become obligated to pay for the proposed services.

This self-pay agreement applies only to the service listed above. If I move to another level of care, authorization may need to be obtained or another self-pay agreement signed.

I have read and understand this agreement. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by the provider. The Agreement is in effect only from the date I sign it, until or unless it is rescinded; the Agreement may never be retroactive.

_____ Signature of Participant

_____ Signature of Therapist

_____ Date

_____ Date