Self-Pay and Out of Network Notice

_____ I acknowledge my insurance _____ has not authorized payment for my services at The Mehra Clinic, PLLC and I have chosen to receive these services without their prior authorization or service rendered by a non-participating provider. I acknowledge I have the option to reschedule these services, but have declined this option. I understand based on my action, I give The Mehra Clinic, PLLC permission not to bill my insurance and to hold me fully responsible for the fees. I understand this decision is entirely my choice, voluntarily, and I will hold harmless The Mehra Clinic, PLLC for any financial risk that may result from my decision.

_____ I am aware that in receiving this service, I am electing to use my out-of-network/out-of-plan benefits. I accept full responsibility for all financial penalties or higher patient portion of the bill resulting from choosing this option over an in-network/in-plan benefit. In doing so, I hold The Mehra Clinic, PLLC harmless for any financial risk that may result from my decision.

_____ I do not have insurance and accept I am expected to pay an estimate of the charges upon checkout. I am aware that this is only an estimate and actual charges may change.

Patient Name: _____ Account #: _____

Date of Service: _____ Service: _____

Insurance Plan: _____ Policy ID#: _____

_____ _____

(Patient Signature) (Date)

Witnessed by:

_____ _____ _____

(The Mehra Clinic Staff Signature) Print Name Date

Patient Name _____

DOB: _____ MR# _____

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___It was emergency treatment
___I could not communicate with the patient
___The patient refused to sign
___The patient was unable to sign because
___Other (please describe)

Signature _____