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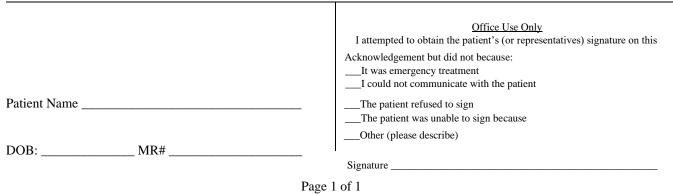
Self-Pay and Out of Network Notice

_____ 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



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