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PATIENT SELF-PAY AGREEMENT

The Self-Pay Agreement is intended to provide Self-Pay patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Clinical Psychology Services, Ltd. The patient/guardian will be responsible for the full payment of charges at the time of service.

The patient has been registered as Self-Pay and will not be covered by a health insurance plan due to the following reason(s): (Please initial below)

_____ I, the patient/legal guardian, do not have health insurance coverage.

_____ The provider performing the service or therapies is not a participating provider with my health insurance. Therefore, the services/therapies are not covered by my health insurance policy.

_____ The scope of services rendered by this provider may not be covered by my health insurance provider. The provider performing the service/therapies is not in-network with my insurance plan.

_____ I, the patient/legal guardian, am choosing not to use my insurance coverage for the services I obtain at Clinical Psychology Services, Ltd.

_____ If non-health insurance coverage is the result of a decision by my insurance plan, I have been informed of the reason, am aware of my plan's formal appeal process, have elected not to appeal. Or am in the process of appealing. In the interim, I have elected to continue to receive services on a self-pay basis and understand that I will not be reimbursed by my health insurance unless I am successful on appeal.

Clinical Psychology Services, Ltd. will not bill any insurance plan now or at a later date, since I, the patient/guardian, have elected to register as a Self-Pay patient at the time of service. This agreement is valid for 1 year from the date below unless changes in payment status include new health insurance coverage.

My signature below is my acknowledgment of receipt of the Patient Self-Pay Agreement.

Patient Name (Please Print)

Date of Birth

Patient/Legal Guardian Signature

Date