LETTER OF ACKNOWLEDGEMENT

Self-Pay Patients (Who Do Not Qualify for Sliding Fee Scale)

Dear Patient of NGHCC,

You are being provided this letter of acknowledgement because you have requested that your visit today be coded as "self-pay". Self-pay patients are those who elect to pay for the service in full on the date of service and who will not be submitting the claim to an insurance carrier. You have requested that this service be coded as self-pay because (**initial one**):

____ You have no health insurance.
____ You have health insurance but you do not want your insurance billed and instead want to pay out of pocket.
____ Other (please explain):____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- Self-pay charges include the Office Visit (professional services provided by your physician), additional Ancillary Services performed by NGHCC (e.g. x-rays, injections, and other procedures not performed by your physician), and Laboratory Testing Services performed by our on-site partner LabCorp.
- All fees for the self-pay service must be paid on the date of service. The standard fees for an Office Visit are $108 for an established patient and $175 for a new patient. However, if your visit goes long because you are addressing multiple concerns with your physician, your Office Visit fees can be as high as $250 for an established patient and $275 for a new patient.
- You will be required to pay the standard Office Visit fee prior to being seen by a physician. Any additional charges for Ancillary and/or Laboratory Testing Services or an extended Office Visit must be paid at check-out.
- If you have insurance or other types of coverage, charges for services received today will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to this Acknowledgement.

By signing below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient Name (Printed) ______________________________ DOB:____________

Patient or Representative Signature ______________________________________
Date ___________ Time __________

If signed by someone other than the patient, please specify relationship to the patient:
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