PREMIER
MOUNTAIN IMAGING CENTER

ACKNOWLEDGMENT OF SELF-PAY
STATUS PATIENT RESPONSIBILITY

Patient Name:_____ **Date of Birth:**_____

Dear Patient,
You are being provided this letter of acknowledgment because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay discount." A self-pay discount is offered to patients 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 BELOW

_____**Patient has no health insurance.**

_____**Patient has health insurance but does NOT want insurance billed, instead wants 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:

• All fees for the self-pay service must be paid on the date of service.

• The self-pay amount covers only the professional services marked below:
ADD-CPT CODE/DESCRIPTION NEXT TO MODALITY

☐ **MRI**_____	☐ **CT**_____
☐ **X-RAY**_____	☐ **ULTRASOUND**_____
☐ **DEXA**_____	☐ **MAMMO**_____

• If you have insurance or other types of coverage, services received today that are included in the "self-pay" discount 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 the self-pay discount.

By my signature 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/Representative Signature:_____ **Date:**_____

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