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**CLIENT ELECTION TO SELF-PAY FOR SERVICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned client, acknowledge that I understand and agree that:

**Union Family Services, PLLC is a participating with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am covered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance plan**

1. **Despite the above, I do not wish for Union Family Services, PLLC to submit a claim to my insurance company for services provided to me by**

**Union Family Services, PLLC.**

1. **Until such time as I may otherwise advise Union Family Services, PLLC in writing, I elect to pay for all services I receive from**

**Union Family Services, PLLC at their out of pocket rate.**

1. **By election to self-pay for services, any payments I make to Union Family Services will not be credited toward satisfying any deductible I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan.**
2. **I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.**
3. **I have freely chosen to self-pay for services after having asked Clinic about payment options and having carefully considered those options.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**