SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

NEW PATIENT SELF-PAY AGREEMENT

This form is provided to you today as an acknowledgement of your request to be seen by our office as a self-pay patient. A self-pay patient elects to personally pay for his/her care on the date of service due. Your self-pay amount covers **ONLY** the ***New Patient Office Visit*** provided by us on that date of service. I understand there may be additional charges for ancillary completed on that date of service.

By initialing and signing below, I acknowledge that I have read and understood the terms of this self-pay New Patient Visit and have been given the opportunity to ask questions. I confirm that I am the patient/guardian. I attest that:

_____ I understand that I will be responsible for all charges related to the services provided to me by UKSM-Wichita Medical Practice Association.

_____ I understand that the $170 charge for the New Patient Office Visit is due in full on the date of service, and there may be additional charges if I receive any ancillary services.

_____ I understand all other terms that go along with the visit (those stated in the Financial Policy)

_____ I understand that I will be able to set up a payment plan for any additional ancillary services received, and that a 35% discount may apply.

New Patient Self-Pay Charge: $170.00

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____