



## ESTABLISHED 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 *Established 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 \$130 charge for the Established 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.

**Established Patient Self-Pay Charge: \$130.00**

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Patient Name (*Print*)

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Date of Birth (MM/DD/YYYY)

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Patient Signature

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Date

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

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Representative Name (*Print*)

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Relationship/Authority to Sign

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Representative Signature

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Date

**Billing Department**

1010 N Kansas, Suite 3049 | Wichita, KS 67214-3199 | (316) 293-3429 | Fax (316) 293-1882

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