

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

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