SERVICE SELF PAY AGREEMENT FORM

Patient:

Office/Location:

Account #:

Provider:

Self Pay No Insurance Waiver:

I am not covered under a health insurance plan and/or choose not to utilize my health insurance plan.

I choose to receive and to pay for the services out of pocket.

Eligible services may qualify for a 25% discount if paid **in full** at the time of service.

The ESTIMATED charges for services are available upon request.

The undersigned accepts full responsibility for all items or services provided, and have agreed to complete the appointment on

Date

Signature of Patient

Patient Name

Signature of CCP Employee Witness

Witness Name

Community Care Physicians complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.