GRANTS PASS
SURGICAL
ASSOCIATES P.C.

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Grants Pass, Oregon 97526
Phone 541-474-5533
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ELECTIVE SELF-PAY

I, ______________________________ (patient/legal guardian), agree to pay the amount of $______________ for ______________________________ (service/therapy).

I have been registered as Elective Self-Pay due to the reason marked below:

☐ The patient/legal guardian does not have insurance coverage.

OR

☐ The provider performing the above service or therapy is not a participating provider with my health insurance. Therefore this service/therapy is not covered by my policy.

☐ The services rendered by this provider are not covered by my health insurance policy.

☐ The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician.

☐ No claim will be sent to my insurance since it's my personal decision not to use my health insurance benefits for the above service/therapy even though I understand that this service/therapy is covered by my policy.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of the amount, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment benefits.

My signature below acknowledges receipt of the Self-Pay Agreement.

______________________________ ______________________________
Patient/Legal guardian signature Date