

PRIVATE PAY AGREEMENT FOR NON-COVERED SERVICES

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Insurance Provider: [Insert Insurance Name]

Policy Number: [Insert Policy Number]

1. Identification of Non-Covered Services

The following services, procedures, or items have been recommended for your care but are generally not covered by your insurance plan:

- [Description of Service 1] - Cost: \$[Amount]
- [Description of Service 2] - Cost: \$[Amount]

2. Financial Responsibility

I understand that my insurance company will not pay for the services listed above because they are deemed [Reason: e.g., cosmetic, experimental, or not medically necessary by insurer]. By signing this agreement, I acknowledge that I am choosing to receive these services and I agree to be personally and fully responsible for the total payment of \$[Total Amount].

3. Payment Terms

Payment is due at the time of service unless other written arrangements have been made. I understand that [Provider Name] will not bill my insurance company for these specific services.

4. Patient Acknowledgment

I have been informed of the estimated cost of the services and have had the opportunity to ask questions. I understand that this agreement is separate from any co-pays or deductibles required for covered services.

Patient/Guarantor Signature: _____

Date: _____

Provider/Clinic Representative Signature: _____

Title: _____