PATIENT ELECTION TO SELF-PAY FOR SERVICES

The Department of Health and Human Services issued updates to HIPAA privacy regulations. Those updates gave patients more control over who has access to their Personal Health Information (PHI), including their own insurance companies. Under HIPAA, patients may opt out of using their insurances benefits to prevent reporting this service to their insurance carrier. Additionally, on February 18, 2010, the HITECH Act regulated that a healthcare provider is required to honor a patient's request to restrict disclosure of PHI to a health plan for purposes other than carrying out treatment (specifically, payment or healthcare operations) if the patient pays the healthcare provider out of pocket in full. This means that if a patient does not wish to use their health insurance, they can request their insurance not be billed.

Please note: This does not apply to Medicare patients because Medicare does not allow patients to opt out of their benefits.

I, _____, the undersigned patient, acknowledge that I understand and agree as of _____ (effective date), that:

1. I am ☐ Uninsured ☐ Underinsured. ☐ I may have insurance in which LifeStance Health is a provider. (Select the appropriate checkbox)
2. The health plan under which I am covered may include benefits for some or all the services provided by LifeStance Health.
3. Despite the above, I do not wish LifeStance Health to submit a claim to my insurance for services provided to me by LifeStance Health.
4. By election to self-pay for services, any payments I make to LifeStance Health will not be credited toward satisfying any deductible I may be subject to under my health insurance.
5. I understand if LifeStance Health does not receive my payment within 60 days of my initial date of service, LifeStance Health reserves the right to revoke this Election to Self-Pay and will bill my insurance for all applicable charges. I acknowledge that I will then be responsible for any co-insurance, co-payment or deductible amounts determined by my insurance as my responsibility.
6. Until such time as I may otherwise advise LifeStance Health by submitting a Revocation of Election to Self-Pay. I elect to pay for all services I receive from LifeStance Health at the current self-pay rate.
7. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.
8. I have freely chosen to self-pay for services after having asked LifeStance Health about payment options and having carefully considered these options.

Patient Name: _____
Patient DOB: _____

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____