Specialty Outreach Clinics for Children
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO

In affiliation with Children's Hospital Colorado

SELF-PAY AGREEMENT

The Self-Pay Agreement is intended to provide Self-Pay patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Specialty Outreach Clinics for Children and University Physician's Inc (UPI). Self-Pay patients/legal guardians should read this agreement carefully before making a decision and proceeding with care.

- Self-Pay patients/legal guardians will receive a bill from University Physicians Inc (UPI) for healthcare services provided by Specialty Outreach Clinics for Children
- A Self-Pay Agreement must be signed for each Specialty Outreach Clinics for Children account for which it applies
- Self-Pay patients/legal guardians will be required to make a minimum deposit at the time of service
- The patient/legal guardian will be responsible for full payment of charges, less the No Insurance Discount (NID) and less the deposit made at the time of service
- UPI will not bill any insurance plan at a later date if the Patient/Legal Guardian elects to be Self Pay at the time of service

The No Insurance Discount (NID) does not apply to:

- Patients that have insurance and select not to utilize their insurance
- Balances after all covered expenses or eligible services to be paid by a health benefits plan
- Amounts due according to the insurance plan Explanation of Benefits (i.e. deductible, co-insurance, and/or co-payment)
- Patients involved in grants or special programs, as these cases fall into a different set of circumstances

The patient has been registered as Self-Pay due to the following reason marked below:

- ❑ The patient/legal guardian does not have insurance coverage

OR

- ❑ The provider performing the above services or therapies is not a participating provider with my health insurance. There form these services/therapies are not covered by my policy
  ___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)
- ❑ The scope of services rendered by this provider may not be covered by my health insurance policy
  ___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)
- ❑ 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
  ___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)
- ❑ No claim will be sent to my insurance since it's my person decision not to use my health insurance benefits for the above service/therapy even though I understand that these services/ therapies are considered covered by my policy (elected – self pay)

The patient/legal guardian elects to have their insurance billed first; the patient/legal guardian will be liable for all balances incurred after all eligible services and covered expenses to be paid by a health benefits plan. The No Insurance Discount (NID) will only apply if the patient's insurance plan does not cover any services.

My signature below acknowledges receipt of the Self Pay Agreement

Patient/Legal Guardian Signature Date

Self-Pay Agreement Explained by:

Staff Name (Print) Date

Attach Label