# Whole Child Therapy

# 5420 W 151st Street

Leawood, KS 66224

P: 913-219-5696

# PATIENT ELECTION TO SELF-PAY FOR SERVICES

I**,** , the undersigned patient, acknowledge that I understand and agree that:

1. Whole Child Therapy, LLC dba Dr Deb’s Center (“Clinic”)is a participating provider with (“Health insurance company”)
2. I am covered by one of the above health insurance company plans.
3. The health plan under which I am covered includes benefits for some or all the services provided by **Whole Child Therapy Dba Dr Deb’s Center for Child and Family Development.**
4. Despite the above, I do not wish **WCT** to submit a claim to my health insurance companyfor services provided to me by **WCT**. I understand that choosing this option will prohibit me from seeking reimbursement directly from my health insurance carrier.
5. Until such time as I may otherwise advise **WCT** in writing, I elect to pay for all services I receive from **WCT** at their standard patient rates.
6. By election to self-pay for services, any payments I make to **WCT** will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with my health insurance company unless otherwise permitted under the terms of my health plan.
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 **WCT** about payment options and having carefully considered those options.

Date: Patient:

Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

Printed Name of Patient or Responsible Party

Capacity of Responsible Party (e.g. parent, guardian, etc.)