REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, **(PATIENT NAME)**, the undersigned patient, acknowledge that I understand and agree that:

1. I previously signed a Patient Election To Self-Pay For Services on _____. **(DATE SIGNED)**
2. I continue to be insured under a health insurance plan offered by

   (INSURANCE/NETWORK) (**"Company"**) with which

   (PROVIDER/PRACTICE NAME) **("Clinic")** continues to participate.

3. By my signature below, I revoke my earlier election to self-pay for services and direct **Clinic** to begin billing my health plan for services provided by **Clinic**.

4. The health plan under which I am covered may limit coverage for services provided by **Clinic** and/or may subject me to a deductible that must be satisfied before any benefits are provided under the health plan.

5. I will be personally responsible for the cost of any services provided to me by **Clinic** that are not covered by my health plan to the extent consistent with the terms of my health plan.

6. **Clinic** will bill for services at their contracted rates as a participating provider with **Company** which may be higher than the ChiroHealthUSA discounted rate **Clinic** makes available to patients who self-pay for services.

7. I have read this Revocation of Patient Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about this form. Any questions I may have had about this form have been answered to my satisfaction.

Date: **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.)