Biofeedback and Family Therapy Center
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Patient Election to Self-Pay for Services Form

I,_____, the undersigned patient (or if patient is a minor, I_____, the patient's responsible party), acknowledge that I understand and agree that:

1. The Biofeedback and Family Therapy Center/Steven C. Kassel, MFT (herein after BFTC/SCK) is a participating provider with the following insurance company: _____.
2. I am covered by one of this insurance company's insurance plans.
3. The health plan under which I am covered included benefits for some or all of the services provided to me by BFTC/SCK.
4. Despite the above, I do not wish BFTC/SCK to submit a claim to the _____company provided to me by BFTC/SCK.
5. Until such time as I may otherwise advise BFTC/SCK in writing, I elect to pay for all services I receive from BFTC/SCK at their stated rates at the time of initiation of treatment.
6. By election to self-pay for services, any payments I make to BFTC/SCK will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with the _____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 question 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 BFTC/SCK 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 themselves).

_____
Printed Name of Patient (or Responsible Party)

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