Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

Tuscarawas County Health Department
Medical Clinic
Patient Election to Self-Pay for Services

I, (Responsible Party) _____, the undersigned acknowledge that I understand and agree that:

1. The Tuscarawas County Health Department Medical Clinic is able to bill medical charges to _____ *(insurance company).*

2. The patient is covered by the above insurance company's health insurance plans.

3. The health insurance plan under which the patient is covered includes benefits for some or all of the services provided by the Tuscarawas County Health Department's Medical Clinic.

4. Despite the above, I do not wish the Tuscarawas County Health Department's Medical Clinic to submit a claim to the patient's insurance company for services provided to the patient on: Date of service _____.

5. I understand that the patient is not eligible for the Tuscarawas County Health Department's sliding fee scale.

6. By election to self-pay for services, any payments I make to the Tuscarawas County Health Department will not be credited towards satisfying any deducible the patient may be subject to under the patient's health insurance 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 the Tuscarawas County Health Department's Medical Clinic about payment options and have carefully considered those options.

Patient's Name: _____ Patient's Date of Birth: _____

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

Date: _____

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