COMPLETE CARE

Self-Pay Payment Agreement

You are being provided this letter of acknowledgement because you have requested that your visit today be coded as “self-pay”.

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- You will be responsible for all charges related to services provided to you by Complete Integrative Care, Complete Care Health Centers and Complete Care Laboratories.
- A ***DEPOSIT*** of $230 will be collected at check in, prior to each appointment with your provider. The $230 will be applied toward your balance for services rendered. **You will receive a bill for the remaining balance for services rendered that day.**
- All fees for service must be paid within 30 days of receiving those services.
- A self-pay discount is offered to patients who elect to pay for lab services in full on the date of service.
- A self-pay discount is offered to patients who elect to pay for all other services (not including lab services) in full within 30 days of receiving those services.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient’s authorized representative.

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Patient or Representative Printed Name DOB

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Patient or Representative Signature Date