FPUCC SELF-PAY OPTIONS FOR NON-COVERED SERVICES

I, ______________________________________, the patient/guardian, acknowledge that I understand and agree that:

1. Franklin Park Urgent Care Center (FPUCC) is a participating provider with ____________________________________ (Insurance Ins. Company) and/or ____________________________________ (Secondary Ins. Company) and/or ____________________________________ (Tertiary Ins. Company).
2. I am currently covered by the insurance company(s) stated above.
3. The health plan I am covered under includes benefits for most of the services provided by Franklin Park Urgent Care.
4. I understand the service I am requesting today may be covered by my primary healthcare provider or a different healthcare facility.
5. The service I am requesting today is ________________________________.
6. I do not wish FPUCC to submit a claim to my insurance company for services provided to me by FPUCC.
7. I elect to pay for all services provided by Franklin Park Urgent Care at their discounted rates.
8. I have read FPUCC Self-Pay options for non-covered 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.
9. I am freely choosing to self-pay for services after having asked FPUCC about payment options and having carefully considered those options.

-- OR --

I, ____, the patient/guardian, attest I do not have medical health insurance.

Date:

Signature of Patient or Guardian: ____.

Printed Name of Patient or Guardian: ____.

Relation of Responsible Party: ______________________________ (self, parent, guardian, etc.).

WAIVER