Step Wright
Medical Footcare

Foot Care Practitioner
2418 HWY 72/221 Greenwood, SC 29649
P: 864-387-1116 FX: 270-220-0519
www.stepwright.com

PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, ______________________________, the undersigned patient, acknowledge that I
(Patient's Name)
understand and agree that:

1. **Step Wright LLC,** is a non-participating provider with ____________________
(Insurance Company)
2. I am covered by one of the **Company** health insurance plans.
3. The health plan under which I am covered includes benefits for some or all of the services provided by **Step Wright LLC**.
4. Despite the above, I do not wish **Step Wright LLC** to submit a claim to **Company** for services provided to me by **Step Wright LLC**.
5. Until such time as I may otherwise advise **Step Wright LLC** in writing, I elect to pay for all services I receive from **Step Wright LLC** at their discounted rates.
6. By election to self-pay for services, any payments I make to **Step Wright LLC** will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with **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 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 asking **Step Wright LLC** about payment options and carefully considered those options.

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 (parent, guardian, etc.)