

## Election to Self-Pay For Services

I, (name below), acknowledge that I understand and agree that:

1. Perlman Counseling and Supervision Services, LLC is participating with some major medical Insurance Plans.
2. I am covered by a major medical insurance plan.
3. Despite the above, I do not wish Perlman Counseling and Supervision Services, LLC to submit a claim to my insurance for services provided to me by Perlman Counseling and Supervision Services, LLC
4. Until Such time as I may otherwise advise Perlman Counseling and Supervision Services, LLC in writing, I elect to pay for all services I receive from Perlman Counseling and Supervision Services, LLC.
5. By Electing to self-pay for services, any payments I make to Perlman Counseling and Supervision Services, LLC will not be credited toward satisfying any deductible. I may be subject to under my health insurance plan with my insurance company unless otherwise permitted under the terms of the health plan.
6. 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 this form. Any questions I may have had about this form have been answered to my satisfaction.
7. I have freely chosen to self-pay for services after having asked Perlman Counseling and Supervision Services, LLC about payment options and having carefully considered those options.

**First Name**

**Middle Name / MI**

**Last Name**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature:**

**Date:**

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