Denver Family Medicine

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Acknowledgement of Self-Pay Status

Thank you for choosing Denver Family Medicine for your health care needs, we are committed to providing you the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient self-pay financial policies.

You are being provided this letter of acknowledgement because you have elected to be self-pay with our practice. A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and for who will not be submitting the claim to an insurance carrier. You have requested that this service be coded as self-pay because (Initial one):

____ You have no health insurance.

____ You have health insurance, other than Medicaid, that we are not contracted with.

____ Other (please explain): _____

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:

- I understand that Denver Family Medicine does not participate in Medicaid, also known as Health First Colorado.
- I attest that I **do NOT** have **Medicaid or are eligible for Medicaid.**
- I understand that I am financially responsible for any charges or fees that are incurred from Denver Family Medicine.
- I understand that if I pay after the date of service that the discounted rate will no longer apply.

By signing 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 duly authorized representative.

_____ _____
Patient Name (please print) DOB

_____ _____
Patient or Representative Signature Date

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