PATIENT ELECTION TO SELF-PAY FOR SERVICES

I, _____ the undersigned patient, acknowledge that I understand and agree that:

1. Dr. Tamara Weiss is currently a provider with Aetna, Blue Cross Blue Shield & Cigna

2. I am covered by one of these health insurance plans.

3. The health plan under which I am covered includes benefits for some or all of the services provided by Dr. Tamara Weiss.

4. Despite the above, I do not wish Dr. Tamara Weiss to submit a claim to my insurance for services provided to me by Dr. Tamara Weiss.

5. Until such time as I may otherwise advise Dr. Tamara Weiss in writing, I elect to pay for all services I receive from her at her stated rates.

6. By election to self-pay for services, any payments I make to Dr. Tamara Weiss will not be credited toward satisfying any deductible I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan.

7. By election to self-pay for services, I understand I will not receive a superbill for reimbursement by my insurance company.

8. 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.

_____ _____

Print Name Signature

_____ _____

Dr. Tamara Weiss Date