



**Self-Pay Agreement Form**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Welcome to Marana Health Center, where our professional staff are committed to providing you with the highest quality medical services.

The following is a statement of our Self-Pay Financial Policy, which we require you to read and sign prior to receiving treatment.

Please be aware as a new patient, you will be charged a range of \$110 to \$281. Established patient charges range from \$66 to \$201. Charges are based on the complexity of your visit. These charges are prior to any discounts listed below. If unable to pay the estimated charges today, we are requesting a down payment of at least 50%.

I understand, as a self-pay patient, that I have the following options for paying my account for today's provider visit **(please initial the option you are choosing)**:

- ❖ \_\_\_\_\_ I can pay the estimated charges and receive a 30% discount for today's services.
- or-
- ❖ \_\_\_\_\_ I can pay \$\_\_\_\_\_ (50% minimum required) deposit today and the remaining balance within 30 days and receive an additional 20% discount.
- or-
- ❖ \_\_\_\_\_ I can pay a minimum of \$\_\_\_\_\_ today and will contact the billing department within three (3) business days at 520-818-3616 to make appropriate payment arrangements.

I fully understand that in the addition to the office visit charges today, there may be additional charges for labs, x-rays, immunizations, tests, etc. I further understand that if there are any additional charges, I will receive a statement with any balance due and agree to pay for all additional charges incurred.

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**Authorization and Release**

I have read and fully understand the Self-Pay Financial Form as outlined above. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all costs associated with the collections process.

By signing this form, I understand I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility.

\_\_\_\_\_  
Printed Patient or Responsible Party Name

\_\_\_\_\_  
MHC Health Center Location

\_\_\_\_\_  
Patient/Responsible Party Signature      Date

\_\_\_\_\_  
MHC Employee Signature      Date