SELF-PAY CONSENT FORM

PLEASE BE ADVISED THAT THE COST OF YOUR OFFICE VISIT IS DUE UPON SERVICES RENDERED. ALSO BE AWARE THAT IF THERE ARE ANY PAP TEST, CULTURES, BIOPSIES, ECT. THEY WILL BE SENT TO THE LAB AND THEIR SERVICE FEE WILL BE BILLED TO YOU. MAKE DOCTORS AWARE BEFORE EXAMINATIONTHAT YOU ARE PAYNG OUTOF POCKET, SO THEY MAY DO THE MOST COST EFFICIENT TESTING TO CATER TO YOUR FINANCIAL SITUATION.

I ____________________________, AM AWARE THAT MY DOCTOR MAY HAVE TO PERFORM TESTING THAT I WILL BE RESPONSIBLE FOR. THOSE FEES INCLUDE ANY BLOODWORK AND/OR LAB TESTING THAT ARE NECESSARY FOR MY VISIT TODAY. I ALSO UNDERTAND THAT THESE COST ARE NOT INCLUDE IN MY OFFICE VISIT FEE, AND WILL BE BILLED TO ME THROUGH THE LAB.

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(PRINT NAME)   (DATE)

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(SIGNATURE)