CLIENT BILLING ELECTIONS

Name _____ **AZ#** _____

☐ **I choose to have all of my services billed to insurance. By doing so I understand that I will not be eligible for a reduced fee.**

- I agree that all services provided to me will be billed to my insurance company.
- I agree that MCCFL will mutually exchange information for the purposes of billing to any third party for which I am or may become eligible.
- I agree to assign all benefits to which I may be entitled toward the cost of service that my family or I may receive.
- I agree to pay my estimated deductible or co-payment at the time of each appointment.
- I agree I am financially responsible for any fees not covered by my insurance.

Signature:_____ Date:_____

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☐ **I elect to apply for a reduced fee or grant program. By doing so I understand that my services <u>will not</u> be billed to third-party insurance. A separate Reduced Fee Application is required.**

- I will submit an application for a reduced fee. If I am eligible I will receive services at a reduced fee.
- I agree to pay my reduced fee at the time of each appointment.
- I understand that the reduced fee program has an expiration date and that I must reapply for the reduced fee program in a timely manner in order to continue to receive the reduced fee.
- When my reduced fee term expires I agree to pay for services at full price until I reapply for a reduced fee.

Signature:_____ Date:_____

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☐ **I agree to pay for all services at full fee. I do not want to apply for a reduced fee and I do not want MCCFL to bill my insurance.**

- I agree to pay for all services at the time of each appointment.

Signature:_____ Date:_____