OSSC

OUTPATIENT SURGICAL SPECIALTIES CENTER LLC

Patient Election to Self Pay

I, _____, the undersigned patient or person responsible for the patient, acknowledge that I understand and agree to the following:

☐ Outpatient Surgical Specialties Center, LLC ("OSSC") and Physicians Anesthesia Services, PC ("PAS") may be a participating provider with my health insurance plan: _____.

- I am covered by the above mentioned health insurance plan and the health plan under which I'm covered includes benefits for some or all of the services provided to me by the OSSC & PAS. _____ *(Initials)*

- Despite the covered service, I do NOT wish that OSSC or PAS submit a claim to my health insurance plan for services provided to me. _____ *(Initials)*

- By my election to Self Pay, any payments I make to OSSC or PAS will not be credited towards satisfying any deductible or cost-share I may be subject to under my health insurance plan, unless otherwise permitted under the terms of my health plan in which I am responsible for. _____ *(Initials)*

OR

☐ I do NOT have health insurance and I am aware that Outpatient Surgical Specialties Center, LLC ("OSSC") and Physicians Anesthesia Services, PC ("PAS") will not be filing a health insurance claim.

I have read the Self Pay Policy Disclosure Form as well as this Election to Self Pay Form and have had the opportunity ask any questions I may have had about the forms. Any questions I may have had about this form have been answered to my satisfaction.
Until such time I may otherwise advise OSSC or PAS in writing, I have freely chosen to elect to pay for all services I receive.

_____ _____
Patient or Responsible Party's Signature Date

_____
Patient and/or Responsible Party's Printed Name & Relationship

_____
Witness Signature

11704 West Center Road Suite 110 Omaha, NE 68144
Phone 402-691-1575 Fax 402-691-1599
www.outpatientsurgeryomaha.com