The ANXIETY *&* STRESS MANAGEMENT INSTITUTE
1640 Powers Ferry Road Building 9, Suite 100 Marietta, Georgia 30067
770.953.0080 Phone, www.stressmgt.net

CLIENT ELECTION TO SELF-PAY FOR SERVICES

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

1. The Anxiety & Stress Management Institute - **LOCATION** is a Non-Participating /Out of Network Provider with all Insurance Carriers (**"Company"**).

2. I am covered by one of the **Company** health insurance plans.

3. The health plan under which I am covered includes benefits for some or all of the services provided by The Anxiety & Stress Management Institute.

4. I elect to pay for all the services that I receive from The Anxiety & Stress Management Institute at their self-pay rates.

5. By election to self-pay for the services noted above, any payments I make to The Anxiety & Stress Management Institute will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with **Company.**

6. 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.

7. The Anxiety & Stress Management Institute is not responsible for denied claims if you choose to submit a superbill to your insurance carriers.

Date: _____ Patient: _____

Signature of client or responsible party if client is a minor or is otherwise unable to sign for him/herself

_____

Printed name of Client or Responsible Party

_____

Capacity of Responsible Party (e.g., parent, guardian, etc.)