Private Pay Agreement

Private Pay Agreement Example Form

| (Provider Name) | _ is accepting me, | (Member Name) |
|---|---------------------|-----------------------|
| as private pay patient for the per | iod of | , and I will |
| be responsible for paying for any | services I receive. | The provider will not |
| file a claim to Medicaid for services provided to me. | | |
| | | |
| Patient Signature | | Date |