West Coast Family Practice
For your Health

11018 N. Dale Mabry Hwy Ste. 401, Tampa, FL 33618
PH: (813) 961-9393 FX: (813) 960-9020
Email: WCFamilypractice@gmail.com

Patient Name (*print name*):

INSURANCE OPT OUT

It is our goal to provide you and your family the very best service possible. As a service to our patients we are participating in a number of health plans, thereby making our services accessible to as many patients as possible, we also want to make our services affordable to you for a Non-Insurance Based Program.

Please initial each line item reviewed and sign below to confirm your understanding of our **OPT OUT** policy.

_____ (Initials) This confirms and identifies your understanding that we will NOT BILL your healthcare insurance provider for the West Coast Family Practice health care services and you **OPT OUT** of this method for payment to West Coast Family Practice LLC. In this case we are not permitted to bill your insurance for any of our health care services.
All payments made to West Coast Family Practice LLC for health care services will be directly billed to you (the patient) as per our Cash Pay Plan.

PLEASE REVIEW and INITIAL FOR "OPT IN CASH PAY " BELOW:

_____ (Initials) You are **OPTING FULL IN as a CASH PAY** customer only. This includes the Physician Visit(s) and West Coast Family Practice health care services, whereas you understand our cash pay fee schedule is based upon allowable rates and is provided to you at the time or before your visit, CASH PAYMENT IS DUE AT THAT TIME OF SERVICE or through our Recurring Payment Option(s). **We will not bill your insurance** for the Provider Visit. You will be responsible for payment for the Provider Visit(s) and services as deemed necessary.

_____ (Initials) Below is our **NO SHOW /CANCELLATION Policy** outline for your understanding:

1.) We request out of respect for other patients waiting for appointment(s), **please notify our office at least 24 Hours prior to your appointment date if you must CANCEL OR RESCHEDULE**. We are available to assist with rescheduling.
2.) If you do not contact our office, and are a **NO SHOW** at your scheduled procedure date/time you **MAY BE BILLED A $10.00 cancellation/no show fee** due to the cost involved for preparations of your scheduled appointment.

PATIENT ACKNOWLEDGEMENT
We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

By my signature below, I acknowledge to have read the above polices and agree to the outlined terms. I understand my responsibilities and the consequences for violation of the financial or cancellation responsibilities. I was given opportunity to ask questions regarding the financial and cancellation policies and understand their impact on my relationship to the practice.

Patient Signature (*or legal guardian, please identify below*):	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation: