ProHealth™ PHYSICIANS
Part of OptumCare®

ProHealthMD.com

# Self-Pay Waiver

I agree to pay the full amount for today's service(s). I notified my doctor/clinician that I do not want today's service(s) submitted to my insurance carrier.

Below are the services I can expect to receive at my appointment. This is a **good faith estimate** based on what was booked at the time of scheduling. I know that if my doctor/clinician needs to provide more services, I will have to pay for the costs myself. For example: labs, x-rays, or other procedures. This is not a contract. I can choose not to get services from ProHealth Physicians.

| | **Procedure Codes** | **Procedure Description** | **Diagnosis Codes** | **Procedure Cost Estimate** |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

Date of Service: _____

Patient Name (printed): _____

Patient Signature: _____

Today's Date: _____