

APPLICATION FOR SELF-PAY PATIENT DISCOUNT

1. This Application is made by _____ [insert patient or legal guardian name] in order to obtain the self-pay patient discount offered by St. Charles Orthopaedic Surgery Associates.

2. In order to make its services accessible to patients lacking health care coverage, St. Charles Orthopaedic Surgery Associates offers a significant discount for self pay patients, as explained in the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy. The undersigned hereby states that _____ [insert patient or legal guardian name] has reviewed the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy and/or has received information regarding the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy.

3. The undersigned hereby states that _____ [insert patient name] is uninsured and meets the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy definition of a "Self Pay Patient" because the patient: (i) has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, AFLAC, or homeowner's policy; (ii) does not claim third party liability (i.e. auto accident) for the patient's health care treatment; (iii) is not eligible for worker's compensation coverage; and (iv) has no other responsible party covering the expenses associated with the care received from St. Charles Orthopaedic Surgery Associates. **EXCEPTION: Medicaid patients who are seen as a follow-up to an Emergency Room visit, will be eligible for the Self Pay discount if all other requirements are met as outlined in items ii, iii and iv.**

Executed upon my oath at to its accuracy and under penalty of perjury on this _____ day of _____, 20____.

Patient or Legal Guardian

If Legal Guardian, state relationship to the patient or legal authority

Witness

Patient declines self-pay discount for the following reason(s): _____

Office Use Only	
Account #: _____	DOS: ____/____/____
Date Posted: ____/____/____	Initials: _____