BOISE STATE UNIVERSITY
HEALTH SERVICES

University Health Services
Self-Pay Agreement

We appreciate you selecting us as your health care provider and look forward to collaborating with you on selecting health care services that will best fit your needs.

I am opting to sign this self-pay agreement form because:

☐ I am currently enrolled in a health insurance plan which I recognize is not accepted at Health Services (ex: Out-of-State Medicaid)	☐ I am currently not insured with ANY health insurance companies/My Health Insurance plan is not an actual insurance product that can be billed to by Health Services	☐ I am choosing to not bill the specific services chosen below to my health insurance company due to privacy issues/other reasons

You can request a **Good Faith Estimate** for these services. Please mark the corresponding box indicting your request:

☐ I **DO** want a Good Faith Estimate ☐ I **DO NOT** want a Good Faith Estimate

Please put a check in the box next to the service(s) that you do ***not*** want billed to your health insurance or that you will be paying for out-of-pocket:

☐ All Services rendered at Health Services ☐ Mental Health Visits ☐ For Date of Service:________________

☐ Sexual Health Visits ☐ Counseling Visits ☐ Visits with:________________________

I, ________________________________ acknowledge that I am responsible for the payment of the services listed above and that they will not be billed to my insurance company upon my request. I am aware that the charges for these services must be paid at the time of service or can be placed on my BroncoWeb account.

If you have any additional questions regarding this agreement please speak with a Health Insurance and Billing staff member. The Health Insurance and Billing Offices are located on the second floor of the Norco building. You may also contact the Health Insurance and Billing staff at 208-426-5616 or at healthinsurance@boisestate.edu

____________________________________ ____________________________________
Printed Patient Name University ID Number

____________________________________ ____________________________________
Patient Signature Date

FOR OFFICE USE ONLY: The section below will be completed by a Health Services staff member

____________________________________ ____________________________________
Witness Date