McLaren Medical Group

BILL AS SELF PAY

I, _____, elect to not use my health insurance
(patient name)

coverage for charges incurred as a result of services on

_____. I understand the charges in full are my
(date of service)

responsibility and I agree to pay in full today.

_____ _____/_____/_____
Signature of Patient/Parent/Legal Guardian **Date**

BILL AS SELF PAY

MM-52 (10/10)

Original-Med Rec. Copy-Patient

Patient Name:

Date of Birth: