Waiver of Insurance Billing for Self-Pay Patients

I request to contract directly with Peachtree Allergy and Asthma Clinic, PC

- ☐ for all services

OR

- ☐ for the following services only—

CPT Code	Description
_____	_____
_____	_____
_____	_____
_____	_____

I agree to pay in full by cash, credit or debit card at the time the above-indicated services are rendered, and understand that I will receive a fee discount as a result of cash payment at the time of service.

I understand that the above-indicated services are being provided outside of any insurance arrangements, waive insurance billing by Peachtree Allergy, and agree that I will not submit insurance claims for these services.

This agreement and waiver is intended to supersede any insurance contract which otherwise might be applicable to myself and /or my dependent, and is to remain in effect unless and until I revoke it in writing.

_____
Patient name (please print)

_____
Signature of Patient (or parent / legal guardian)

_____
Date