REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES

The Department of Health and Human Services issued updates to HIPAA privacy regulations. Those updates gave patients more control over who has access to their Personal Health Information (PHI), including their own insurance companies. Under HIPAA, patients may opt out of using their insurances benefits to prevent reporting this service to their insurance carrier. Additionally, on February 18, 2010, the HITECH Act regulated that a healthcare provider is required to honor a patient's request to restrict disclosure of PHI to a health plan for purposes other than carrying out treatment (specifically, payment or healthcare operations) if the patient pays the healthcare provider out of pocket in full. This means that if a patient does not wish to use their health insurance, they can request their insurance not be billed.

I, _____, the undersigned patient, acknowledge that I understand and agree as of _____ (effective date), that:

1. I am ☐ Uninsured ☐ Underinsured. ☐ I may have insurance in which LifeStance Health is a provider. (Select the appropriate checkbox)
2. I previously signed a Patient Election to Self-Pay for Services on: _____
3. I continue to be insured under a health insurance plan with which LifeStance Heath may be a provider.
4. By my signature below, I revoke my earlier election to Self-Pay for Services and direct LifeStance Health to begin billing my health insurance for services provided by LifeStance Health.
5. The health insurance plan under which I am covered may limit coverage for services provided by LifeStance Health and/or may subject me to a deductible that must be satisfied before any benefits are provided under the health plan.
6. I will be personally responsible for the cost of any services provided to me by LifeStance Health that are not covered by my health plan to the extent consistent with the terms of my health plan.
7. LifeStance Health will bill for services at their contracted rates as a participating provider with my insurance, which may be higher than the self-pay rate LifeStance Health makes available to patients who self-pay for services.
8. I have read this Revocation of Patient Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about this form. Any questions I may have had about this form have been answered to my satisfaction.

Patient Name: _____
Patient DOB: _____

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____