PATIENT AGREEMENT TO SELF-PAY STATUS
ACKNOWLEDGEMENT OF NON-CONTRACT INSURANCE STATUS

*In the event that your insurance status changes
(ALL patients must sign)

I UNDERSTAND THAT THE JACKSON REGIONAL WOMEN'S CENTER is no longer accepting or contracted with my current insurance carrier (if it changes). I have the option to be seen as a self-pay or be responsible for any Out-Of-Network charges for the services rendered to me by JACKSON REGIONAL WOMEN'S CENTER physicians.

_________________________________ _____________________
Patients Signature Date

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Legal Guardian, Parent, Responsible Party (if needed)

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Witness for Jackson Regional Women's Center