

Self-Pay Patient Payment Agreement

I understand that I will be responsible for all charges related to the services provided to me by the UCLA Health System.

I understand that the charges presented to me are due in full on the day of service, unless arrangements have been made with the physician. I also understand that these charges are solely in relation to professional services provided by the physician, and or other services that are performed **in the office.**

I will also be responsible for all fees billed to me separately from the UCLA Laboratory. These charges will be in relation to all lab work up required to be sent to the UCLA Lab.

All other services that require for you to go elsewhere such as x-rays, MRI's, CT's, etc., are not included in your fee. You will be billed separately for these services from the practicing location.

The patient certifies that he/she has read and agreed to the forgoing, received a copy thereof, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Name (Please Print)

UCLA Medical Record No.

Patient Signature

Date

UCLA Representative (Please Print)

Signature/Date