## **B.45** Private Pay Agreement

I understand \_\_\_\_\_\_\_ (Provider Name) \_\_\_\_\_\_\_ is accepting me as a private pay patient for the period of \_\_\_\_\_\_\_, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

В