COMMUNITY FIRST HEALTH PLANS

PRIVATE PAY AGREEMENT

I understand that _____
(PROVIDER NAME)

is accepting me, _____,
(MEMBER NAME)

as a private pay patient for the period of _____, and I will be responsible for the payment of any services that I receive.

The Provider will not file a claim to Community First Health Plans for services provided to me.

Patient Signature: _____

Date: _____

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