Sara L. Watts
THERAPY • COACHING • CONSULTING • TRAINING

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Insurance Opt-Out & Private-Pay Election

Therapy services • Voluntary election for clients with commercial insurance

Client name

Date of birth

Commercial insurance plan

Effective date

1. My choice

I choose to pay privately for therapy with Sara L. Watts, LMFT, rather than use my commercial insurance for the services identified below. I understand I may contact my plan about covered services and participating providers. I have had the opportunity to ask questions and make this choice voluntarily.

2. Fees and payment

I am responsible for the agreed fees, subject to applicable law and the practice's financial agreement. Private payments may not count toward my deductible or out-of-pocket maximum. This form does not authorize charges beyond our agreed fees or waive billing protections.

Services / session length

Agreed fee per session ($)

3. Claims and reimbursement

I request that the practice not submit insurance claims for these services, where permitted. A receipt or superbill may be requested where permitted; reimbursement is not guaranteed. Submitting a superbill myself may disclose diagnosis and treatment information to my plan. This election does not override applicable law or the clinician's insurance contracts.

4. Good Faith Estimate and future changes

When required, I will receive a separate written Good Faith Estimate. This form is not that estimate and does not waive my right to one or my right to dispute a qualifying bill. I may request a change to this election for future services; billing arrangements must be confirmed before the affected appointment.

Optional privacy request

☐ I request no disclosure to my health plan for payment or health care operations of information relating solely to services paid out of pocket in full, unless disclosure is required by law. Where HIPAA applies, this restriction must be honored when its conditions are met. It does not prevent all legally permitted or required disclosures.

Services or dates covered by this request

I have read this form, understand my choice and financial responsibility, and have had my questions answered. Signing does not cancel my insurance or waive rights that cannot legally be waived.

Client / authorized representative signature (type or sign)

Date

If representative: printed name, relationship and authority to sign

Practice use: Confirm that this election is allowed by applicable contracts and rules. Do not use this form as a Medicare private contract or for Medicaid / Medi-Cal or other government coverage; those arrangements require separate review.

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