



**www.heartfeltpediatrics.com**  
Mailing address only: **1001 SW Disk Dr.**  
**Suite 250**  
**Bend, OR 97702**  
**Phone: 541-859-3550**

## OPT-IN/OUT OF INSURANCE CLAIM SUBMISSION

This document serves for compliance with HIPAA/HITECH Regulation [Section 13405 of Subtitle D of the HITECH Act (42 USC 17935)], which states the following:

Sec. 13405. Restrictions on certain disclosures and sales of health information; accounting of certain protected health information disclosures; access to certain information in electronic format; requested restrictions on certain disclosures of health information.

In the case that under paragraph (a)(1)(i)(A) of section 164.522 of title 45, Code of Federal Regulations, an individual requests that a covered entity restrict the disclosure of the protected health information of the individual, notwithstanding paragraph (a)(1)(ii) of such section, the covered entity must comply with the requested restriction under these circumstances:

- Except as otherwise required by law, the disclosure is to a health plan for the purposes of carrying out payment or health care operations (not for the purposes of carrying out treatment).
- The protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

This means that if you, the patient, do not wish to use your health insurance or med-pay, you can request that your insurance not be billed. A PPO cannot require you, the patient, to file a claim. However, we require clients who select this option to complete the following attestation requesting the restriction.

For more information, visit <https://www.govinfo.gov/app/details/USCODE-2023-title42/USCODE-2023-title42-chap156-subchapIII-partA-sec17935>



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**PATIENT ELECTION TO SELF-PAY FOR SERVICES**

I, **(PRINT PARENT/LEGAL GUARDIAN NAME)** \_\_\_\_\_,  
the undersigned parent/legal guardian of **(PRINT CHILD'S NAME)** \_\_\_\_\_,  
acknowledge that I understand and agree that:

1. Heartfelt Pediatrics LLC and its providers are in-network with my health insurance company, \_\_\_\_\_, referred to as "Company."
2. I am covered by one of the health insurance programs offered by the Company.
3. The health plan under which I am covered includes benefits for some or all of the services provided by Heartfelt Pediatrics LLC.
4. Despite the above, I do not wish Heartfelt Pediatrics LLC to submit a claim to my health insurance company for services they have provided to me.
5. Until such time as I may otherwise advise Heartfelt Pediatrics LLC in writing, I elect to pay for all services I receive from Heartfelt Pediatrics at their rates.
6. By election to self-pay for services, any payments I make to Heartfelt Pediatrics will not be credited toward satisfying any deductible that I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan.
7. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about it. Any questions I may have had about this form have been answered to my satisfaction.
8. I have freely chosen to self-pay for services after having asked Heartfelt Pediatrics LLC about payment options and having carefully considered those options.

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Printed Name of Parent/Legal Guardian**

\_\_\_\_\_  
**Today's date**



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**REVOCATION OF PATIENT ELECTION TO SELF-PAY FOR SERVICES**

I, **(PRINT PARENT/LEGAL GUARDIAN NAME)** \_\_\_\_\_,  
the undersigned parent/legal guardian of **(PRINT CHILD'S NAME)** \_\_\_\_\_,  
acknowledge that I understand and agree that:

1. I previously signed Heartfelt Pediatrics LLC Patient Election to Self-Pay for Services on (date) \_\_\_\_\_.
2. I continue to be insured under my (insurance company) \_\_\_\_\_ health insurance plan with which Heartfelt Pediatrics continues to participate.
3. By my signature below, I revoke my earlier election to self-pay for services and direct Heartfelt Pediatrics to begin billing my health plan for services provided to me.
4. I am aware that the health plan under which I am covered may limit coverage for services provided by Heartfelt Pediatrics LLC and/or may subject me to a deductible that must be satisfied before any benefits are provided under the health plan.
5. I will be personally responsible for the cost of any services provided to me by Heartfelt Pediatrics that are not covered by my health plan or which my health plan refuses to pay to the extent consistent with the terms of my health plan.
6. Heartfelt Pediatrics will bill for services at their contracted rates as a participating provider with my health insurance company, which may have higher rates than the office rates offered by Heartfelt Pediatrics LLC and those available to patients who self-pay for services.
7. I have read this Revocation of Patient Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about it. Any questions I may have had about this form have been answered to my satisfaction.

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Printed Name of Parent/Legal Guardian**

\_\_\_\_\_  
**Today's date**