MEDICARE, MEDICAID, GOVERNMENT SPONSORED INSURANCE DECLARATION

PATIENT ATTESTATION

By electronically signing or clicking on this form, I hereby certify, represent, and attest that:

1. I am voluntarily seeking medical services on a self-pay (cash-pay) basis.
2. At the time of signing this document and receiving services, I do not have active Medicare, Medicaid, or any other federal, state, or government-sponsored healthcare coverage that would prohibit, restrict, or otherwise affect my eligibility to receive the requested services on a cash-pay basis.
3. I have disclosed all health insurance coverage available to me, including any federal, state, commercial, employer-sponsored, marketplace, or government-funded healthcare plans.
4. I understand that the Provider is relying upon my representations in determining my eligibility to receive services on a self-pay basis.
5. I agree to promptly notify the Provider if I become enrolled in, eligible for, or covered by any federal, state, or government-sponsored healthcare program before, during, or after the course of treatment.

ACKNOWLEDGMENT OF LEGAL OBLIGATIONS

I understand and acknowledge that:

1. Providing false, misleading, incomplete, or fraudulent information regarding my insurance status may constitute fraud and may violate federal and/or state laws.
2. Misrepresenting my eligibility for Medicare, Medicaid, or other government-sponsored healthcare programs may subject me to civil penalties, criminal penalties, fines, repayment obligations, exclusion from government healthcare programs, and other legal consequences as permitted by applicable law.
3. The Provider reserves the right to discontinue treatment, reclassify services, bill applicable insurance programs where legally required, seek reimbursement, and pursue any other remedies available under law if any information provided by me is determined to be false or misleading.
4. I am solely responsible for the accuracy and completeness of the information I provide regarding my insurance status and eligibility.

INDEMNIFICATION

To the fullest extent permitted by law, I agree to indemnify and hold harmless the Provider, its owners, employees, contractors, agents, and affiliates from any claims, damages, penalties, costs, expenses, or liabilities arising from or related to any false, inaccurate, incomplete, or misleading information I provide regarding my insurance status or eligibility.

AUTHORIZATION TO VERIFY COVERAGE

I authorize the Provider to verify my insurance status and eligibility through available databases, payers, governmental agencies, clearinghouses, and other lawful sources. I understand that discovery of undisclosed coverage may result in changes to billing practices and financial responsibility.

CERTIFICATION

I certify under penalty of perjury that the information provided in this Attestation and Disclosure is true, accurate, and complete to the best of my knowledge.

I have read this document in its entirety, understand its contents, have had ample opportunity to ask questions and voluntarily sign it.

PATIENT SIGNATURE

Patient Name: _____

Signature: _____

Date: _____

Revised June 2026