# PATIENT SELF-PAY PAYMENT AGREEMENT

Date_____

Patient Name_____

Address_____

City_____ State_____ Zip Code_____

Legal Guardian Name_____

**Self-Pay Rate: $_____**

**Service Type:_____**

I understand that I am required to make payments for services the same day that they are provided to me. I understand that MVP Physical Therapy is providing a convenience discount for services on the basis that no insurance or personal billing will be done. I also understand that if I do not pay for services on the day performed, MVP Physical Therapy will bill me directly for the entire cost of the treatment and I will not be eligible for the self-pay discount.

_____ _____

Patient/Responsible Party Date

_____ _____

MVP Office Coordinator Date