Diana Boutté, PMHNP-BC
7489 Right Flank Rd. #330
Mechanicsville, VA 23116

Self-Pay Agreement

I, ______________________________, have been notified by my provider, Diana Boutté, PMHNP that my treatment will not be billed through my insurance carrier.

I have _________________________ insurance, though am electing to not use this insurance and am aware that I am personally responsible for the payment of these services.

I have chosen to receive treatment with Diana Boutté, PMHNP on a self-pay basis starting on ______________, which is no earlier than the signature date.

I am aware, that I may be able to receive this treatment by other providers in the community who will utilize my insurance.

Client signature: ______________________________________

Date: ________________________

Witness signature: ____________________________________

Date: ________________________