TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
at the Permian Basin
School of Medicine

Client Acknowledgment Statement

Date: Patient's Name: _____

You are being provided this letter of acknowledgement because you have requested that your child's telehealth encounter be "self-pay" and that you are receiving a "self-pay discount." A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and acknowledge TTUHSC will not be submitting the claim to an insurance carrier.

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

• All fees for the self-pay service must be paid on the date of service.

• The self-pay amount covers only the professional services provided by your physician. You are financially responsible for all ancillary services, for example laboratory, x-ray or other services.

Texas Medicaid

"I understand that, in the opinion of Texas Tech Health Sciences, the services or items that I have requested to be provided to my child may not be covered under the Texas medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Specific Service(s): Telehealth encounter via Campus Health Connect

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Patient or Representative Signature _____Date _____

Witness Signature _____Date _____

Texas Medicaid Provider Procedures Manual, Section #1.4.9.1 (http://www.tmhp.com)