



**BlueCross BlueShield  
of Texas**

## **Private Pay Agreement**

I understand that \_\_\_\_\_ is accepting me as a private pay patient for the period of \_\_\_\_\_, and I will be responsible for paying for any services that I receive. The provider will not file a claim to Medicaid for the services that are provided to me.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_