

Sarah Y Kerem, MFT

Licensed Marriage and Family Therapist MFC 39860

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MEDI-CAL PRIVATE PAY ACKNOWLEDGMENT

Client Name:	_____ _____
Date of Birth:	_____ _____
Responsible Party (if applicable):	_____ _____

1. This practice is not participating in Medi-Cal for the psychotherapy services addressed by this form and is not agreeing to bill Medi-Cal for those services.
2. I understand that services from this practice are being provided on a private-pay basis, and I am personally responsible for payment, subject to applicable law.
3. No promise has been made that Medi-Cal or any other payer will reimburse me for these services.
4. I understand that I may instead seek services from a provider, clinic, or program that participates in Medi-Cal.
5. I understand that this form is intended only to address Medi-Cal status and does not replace any separate informed consent, financial policy, or other practice forms.
6. I have had the opportunity to ask questions and I acknowledge my choice to receive services from this practice on a private-pay basis.

Client / Responsible Party Signature	Provider Signature
_____	_____
Print Name: _____	Print Name: _____
Date: _____	Date: _____