



FLORENCE PARK
PEDIATRICS

Patient Self Pay Agreement

I, _____ (Patient Name) have
requested _____ (Practice Name) to provide the
following services to me and/or my child with the understanding that my physician is not
participating with my insurance plan at this time and therefore these services will not be covered.

Date of Service(s) and List of Service(s) to be provided:	Estimated Cost:
_____	_____
_____	_____
_____	_____
_____	_____

I understand that by signing this acknowledgement I will be responsible to pay for all of the
providers' charges for the services rendered to me and/or my child.

Signed by: _____
Signature of Patient or Legal Guardian

Patient Date of Birth

Print Name of Legal Guardian

Relationship to Patient