Patient Self Pay Agreement

I have requested that Briarvista Pediatrics 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.

OR

- ☐ My child is currently uninsured and therefore I am responsible for full payment of all services.

Patient's Name: ____

Date of Birth: _____ / _____ / _____

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

I understand that the above is an *estimate* of the cost for today's visit, and that based upon actual services provided, the actual cost may be higher or lower. 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.

Signature: ____ Date: _____ / _____ / _____

Printed Name: __________________________________ Relationship to Patient: _____________________

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