Monarch pediatrics

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# Patient Self Pay Agreement

I,_____(Patient Name) have

requested_____ Monarch Pediatrics 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**