



Address: 5410 114<sup>th</sup> St, Lubbock, TX, 79424  
Phone: (806) 853-5233  
Fax: (806) 451- 4786

### Patient Self Pay Agreement

I, \_\_\_\_\_ (Patient Name) have

requested Leaps & Bounds Pediatrics, PLLC 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