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Diplomate American Board of Pediatrics

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Self-Pay Form

I_____ understand that I have chosen to be self-pay for my child, _____ on this date: _____. I am aware that this date of service will not be billed to any insurance later on, and payment I am making today is non refundable. I acknowledge that if I wish to have another date of service not be filed with insurance that I will submit another written request form. I accept that I am personally responsible for the payment of the services rendered and not any other insurance company.

Signed:_____ Date:_____

Print Parent's Name_____

Print Child's Name_____