Patient Self Pay Agreement

I,____(Patient Name) have requested All Starr Pediatrics, LLC 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.

____ _________________________

Patient or Legal Guardian **Patient Date of Birth**

Patient Date of Birth

____ _________________________

Print Name of Legal Guardian **Relationship to Patient**