STEEPLECHASE
PEDIATRIC CENTER

NCMC Office
21216 Northwest Fwy, Ste. 470
Cypress, TX 77429
Tel: 281-469-2838
Fax: 281-469-9314

Cypress Skinner Office
13611 Skinner Rd, Ste 145
Cypress, TX 77429
Tel: 281-304-7337
Fax: 281-469-9314

Cypress Springs Office
7626 Fry Road, Ste 500, Cypress, TX 77433
Tel: 281-469-3305
Fax: 281-469-9314

Katy Office
22762 Westheimer Pkwy., Ste. 560, Katy, TX 77450
Tel: 281-921-0590
Fax: 281-469-9314

Fulshear Office
11605 S Fry Rd., Ste. 108
Fulshear, TX 77441
Tel: 281-469-4340
Fax: 281-239-2104

PRIVATE PAY AGREEMENT

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

I understand STEEPLECHASE PEDIATRIC CENTER is accepting my child/ children as a private pay patient(s) for the following date(s): _____, and I will be responsible for paying for any services received. These charges will not be billed to my insurance company for the following reason(s) *(Check one or all that apply)*:

- ○ Insurance benefits were verified, and the following services are NOT covered:

  _____
- ○ The provider is not participating with my health insurance plan.
- ○ Medicaid HMO panel is closed to new patients.
- ○ I am a new enrollee with my insurance, but illegibility cannot be verified.
- ○ I am requesting private pay vaccine (s) for my child/children. I am aware that this is a non-Medicaid benefit.
- ○ I do not have any health insurance for my child(ren), and I am requesting to be private pay.
- ○ Other: _____

Signature: _____ Date: _____