Azalea Pediatrics

Amy E. Brown, MD

Patient Self Pay Agreement

I,____(Patient Name) have

requested Azalea 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 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**