SOUTH ATLANTA PEDIATRICS, P.A.
Pediatrics & Adolescent Medicine
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Self- Pay Agreement

(Please initial all fields)

_____ I understand that South Atlanta Pediatrics, P.A. provides the option to self-pay or reschedule my child (ren)'s appointment if there is a delay or lapse in insurance coverage.

_____ I understand that if I choose to self-pay for my child (ren)'s visit and would like to be reimbursed, I must contact the office and provide insurance information within **30 days of the visit.**

_____ I understand that the refund process can take 6 to 8 weeks or longer to be completed.

_____ I understand that my reimbursement amount may be less than the amount paid at the time of service.

_____ I understand that charges presented to me are due in full on the day of service and that I will be responsible for all charges related to the services provided by South Atlanta Pediatrics.

_____ I understand that these charges are solely in relation to professional services provided by the physician, and/or other services that are performed in the office.

I have read and agree to adhere to the statements listed above. I have declined to reschedule my child (ren)'s appointment appointment(s) and consent to being self-pay for today's visit.

Patient Name: _____ DOB: _____
Parent/Guardian Name: _____
Parent/Guardian Signature: _____ Date: _____

Witness/Sappa Rep: _____
Account#:_____