1809 S. Church Street
Suite 302
Smithfield, VA 23430
Phone: 757-780-8400
Fax: 757-432-3279

Patient Self Pay Agreement

I,_____(Patient Name) have

requested Infinity Pediatric & Adolescent Medicine 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.

Signed by: _____ _____

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

_____ _____

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