Pavilion Family Medicine

SELF-PAY AGREEMENT

Patients Name: ___________________________________ Date of Birth: ______________

The following is a statement of our Self-Pay Agreement which we require that you read and sign prior to receiving treatment.

I understand that I will be responsible for all charges related to my care at Pavilion Family Medicine.

I understand that charges presented to me are to be paid in full at the time of service, unless arrangements have been made in advance with the Practice Manager. I also understand that these charges are solely related to services provided by the physician and nurse practitioner and/or other services that are **performed in the office**.

I understand that there may be additional charges for any procedures performed at my office visit. If any procedures are performed, I will receive a bill which must be paid prior to or at my next office visit.

I have read and fully understand the Self-Pay Agreement outlined above. In the event it is necessary to turn my account over to a collection agency, I have been made completely aware that I am responsible for any and all additional costs and fees associated with the collection process.

My signature below acknowledges receipt of the Self-Pay Agreement and Self-Pay Fee Schedule

Name: _____________________________________
Patient/Legal Guardian

Signature: __________________________________ Date: _____________________