Self-Pay Patient Agreement

Patient Name:	Patient Date of Birth:	Patient Email:
Patient Phone:	Patient Address:	

Item/Service/Procedure Code(s):	
Description of Service(s):	
Anticipated Date(s) of Service:	

Estimated Cost: $ _____

Shodair Children's Hospital allows payment plans and has financial assistance available for those who qualify. Please reach out to the billing office once you receive your first statement if you would like to discuss these otions.

☐ Yes, I want to receive these items or services. I understand that I will be responsible for all charges related to the above services provided to me by Shodair Children's Hospital as I either do not have health insurance or have requested Shodair Children's Hospital to not submit the above services to my health insurance provider. I understand I will be contacted if any additional services need to be performed.

_____ _____

Signature of Patient or Authorized Representative Date