5716 Jackson Street
Alexandria, LA 71303

Ph. 318-767-6503
Fax. 318-703-8257

Patient Self Pay Agreement

I,_____(Legal Guardian/Guarantor Name) have requested JACKSON STREET PEDIATRICS to provide the following services to me and/or my child _____ (Patient Name and Date of Birth) 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 Legal Guardian/Guarantor — Date

_____ _____

Print Name of Legal Guardian/Guarantor — Relationship to patient