Acknowledgement of Financial Responsibility

I understand that payment of all medical care is due and payable at the time of service. With dependents of divorced parents, responsibility and payments shall be that of the guardian bringing the child for treatment.

I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company.

I understand that I am responsible for any costs incurred in the collection of patient's accounts in case of default including reasonable attorney fees and court costs.

I hereby grant permission to Center City Pediatrics to release any pertinent information to my insurance company upon request; I also authorize payment directly to Center City Pediatrics.

A photocopy of this authorization shall be considered as effective and as valid as the original.

By signing below, I acknowledge and accept the above.

Parent Signature: _____

Child's Name: _____

(please print)

Child's Date of Birth:_____

Date: _____