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## Self- Payment Agreement Form

Your signature on the bottom of this form signifies that you understand your responsibility for payment of all services performed today. At check-in, you are required to pay a minimum of \$150.00 for a new patient office visit or \$100.00 for an established patient visit.

This is the minimum that you will be asked to pay today. If any additional services were performed today besides the office visit of it the office visit warrants higher level of care than anticipated you will be responsible for the remaining balance. A bill will be sent to you from our billing company.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative Name and Relationship to patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date