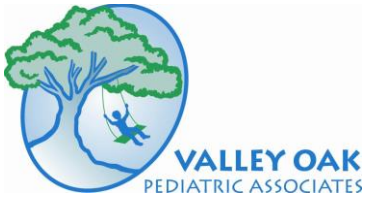

Statement of Patient Financial Responsibility

Childs Name: _____ DOB: _____
Childs Name: _____ DOB: _____
Childs Name: _____ DOB: _____
Childs Name: _____ DOB: _____

Valley Oak Pediatrics Associates appreciates the confidence you have shown in choosing us to provide for your child/children's health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-insurance as determined by your contract with your insurance carrier. Some insurance carriers require the member to pay a co-pay for services rendered. We expect co-pays at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Valley Oak Pediatrics Associates, for providing services to the above named patient(s). I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Valley Oak Pediatrics Associates, the full and entire amount of bill incurred by me or the above named patient(s); or, if applicable any amount due after payment have been made by my insurance carrier.

Date: _____

Print Name: _____ Signature: _____
(Parent/Guardian) (Parent/Guardian)