Primary Care Partners
Affiliated with
Atlantic Health System

Patient Self Pay Agreement

I, _____ (Patient Name) have requested _____ (care center name)- a Primary Care Partners Affiliate to provide the following services to me and/or my child as a self-pay patient.

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 Patient or Legal Guardian **Patient Date of Birth**

_____ _____

Print Name of Legal Guardian **Relationship to Patient**