

SELF PAY POLICY STATEMENT

We ask that payment be made for services rendered by Dr. Barbara Aquino at the time of service. We cannot accept partial or deferred payments. We kindly suggest that you ask a receptionist for an estimate of the cost of the visit before the patient is seen. Please understand that you are ultimately responsible for attorney's fees and cost of collections in the event of default. We are sorry for any inconvenience that this may cause you.

Please sign this policy statement stating that you understand its importance and meaning.

Patient Name _____

Parent Signature _____

Date of Service _____