Financial Agreement

of 18yr and older patient with parent/legal guardian financial support

By signing this form I acknowledge that I have read, understood, and agree to Grandville Pediatrics Financial Policy set forth. (if you would like a copy of the Financial Policy, please ask the receptionist for one.)

FOR PATIENTS 18 YRS AND OLDER
(must sign if parent is to continue paying for medical services by Grandville Pediatrics):

By signing this form, I agree to allow, ____, my

_______________________________, to be financially responsible for all of the expenses related to the medical care I may receive at Grandville Pediatrics, I authorize the staff of Grandville Pediatrics to disclose only the information specifically regarding my financial account with Grandville Pediatrics to this individual without constraint. I understand that I or my Parent/Legal Guardian may revoke these privileges in writing at any time making my financial account solely my responsibility. I acknowledge that this authorization does not authorize Grandville Pediatrics to fully disclose my medical record, and I must fill out the appropriate medical release of information to allow this.

____
Printed name of Patient

____ __________________
Signature of Patient Date

____
Printed name of Parent/Legal Guardian

____ __________________
Signature of Parent/Legal Guardian Date