SEASHORE PEDIATRICS

This document will serve as a Payment Agreement between Seashore Pediatrics and the following:

Parent Name : _____ Today's Date : _____

Patients Name : _____ Patients DOB : _____

**Please place a check mark beside the appropriate agreement below:**

- _____ I am aware that I owe Seashore Pediatrics the balance of $_____. I agree to make payments in the amount of $_____ every 30 days until this balance is paid in full.
- _____ I am aware my child's insurance is not showing active coverage for today's appointment. The estimated charge for today's appointment is $_____. I agree to make payments in the amount of $_____ every 30 days until this balance is paid in full.
- _____ I am aware my insurance may not cover my child's appointment today. The estimated charge for today's appointment is $_____. I agree to make payments in the amount of $_____ every 30 days until this balance is paid in full.

I understand that this is a binding agreement and if I default on this agreement my child may be released from Seashore Pediatrics until the balance is paid in full.

Parent Signature: _____

Employee Signature: _____