Kenneth A. Whittaker, MD, PC

Self-Pay Agreement

You have notified our office staff that you are currently without health care coverage or are choosing not to have coverage. We would like to take this opportunity to let you know the options that are available to you and your family.

____ We participate in the Vaccines for Children (VFC) program. We can provide vaccines to your child for a minimal cost for the administration of the vaccine.

____ We offer a 20% courtesy discount for services at your visit. This does not include vaccines.

____ Balances over $300 will require a payment agreement.

____ Your child's visit may include services that incur additional fees. These services can include and are not limited to: developmental assessments, questionnaires, medication, supplies, et. These charges may not be known prior to the exam.

I have read and understand this policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____

On completion, we will provide you with a copy for your records.