Pediatrics, C & C Medical Associates

Dear Parents or Guardian,

I, _____, understand that under the terms of my Insurance Company's contract agreement with Pediatrics, C & C Medical Associates that exclusions and limitations to my plan for charges on all services rendered, will solely by my responsibility. _____Initials

I, _____, agree to pay in full to Pediatrics, C & C Medical Associates., charges for all services rendered that is NOT COVERED by my Insurance Company within 30 days after receiving a statement / bill from C & C Medical Associates Pediatric Clinics _____Initials

I, _____, in the event of dissolution of marriage am financially responsible for medical bill incurred which includes any co-pay's, deductible or non-covered services and agree to pay C & C Medical Associates Pediatric Clinics at time of services. _____Initials

I, _____, agree that in the event that my child is brought to C & C Medical Associates Pediatric Clinics by someone other than a Parent / Legal Guardian it is my sole duty and responsibility to send payment for any co-pay's, deductibles or non-covered services. _____Initials

I, _____, authorize C & C Medical Associates Pediatric Clinics to leave phone messages at my home or place of employment.

_____Initials

Signature _____ Date _____