PATIENT RESPONSIBILITY OF PAYMENT

I, (Parent/Guarantor Name) acknowledge that I may have financial responsibility to the Chicago Pediatric Therapy & Wellness Center, LLC for any services not reimbursed by insurance. Although my insurance company may be billed directly, I will be responsible for all copays, deductibles, coinsurance and non-covered services of my insurance provider.

Child's Name

Date of Birth

Parent/Guarantor Signature

Date

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