Southern Indiana pediatrics

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Financial Responsibility Agreement

I _____, understand, that by signing this form, accept financial responsibility for _____ (Name of Child). I understand it is my responsibility to provide my child's insurance information to Southern Indiana Pediatrics within 30 days of signing this agreement. However, if I fail to do so, or my insurance does not cover the services provided, I will be responsible for the balance. All balances are due within 30 days of receipt.

_____
Witness

_____ _____
Parent / Guardian/ Responsible Party Date