FAIRFAX PEDIATRIC ASSOCIATES

3650 Joseph Siewick Drive, Suite 101 Fairfax, VA 22033

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND WAIVER FOR **TELEPHONE CONSULTATIONS**

My physician has offered me the option of having a telephone consultation in place of returning for an office visit for my child. I understand that my health care insurance benefits may not cover the cost of this consult. In the event that my insurance company declines to reimburse Fairfax Pediatric Associates, P.C., I agree to assume full financial responsibility. The average charge for this consult is $60.00, but it can be as low as $40.00 and as high as $100.00.

I have read the above information and:

_____ Consent and agree to pay for telephone consultation.

_____ Decline the telephone consultation.

_____
Print Patient Name

_____
Print Guarantor Name

_____ _____
Guarantor Signature Date

For Office Staff

_____ _____
Account Number scanned date