PGV Pediatrics, P.A.
3417 Gaston Avenue, Suite 845
Dallas, TX 75246

Self-Pay Agreement

I understand that PGV Pediatrics is accepting me as a self-pay patient for the date of service _____, and I will be responsible for paying for any services that I receive. The provider or parent will not file a claim to the patient's Medical Coverage for the services that are provided to me.

Patient Name_____

Parent Name_____

Parent Signature_____ Date _____