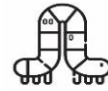


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**Jupiter  
Peds**

 **TopLine MD Alliance**

## **Patient Financial Responsibility Form**

INDIVIDUAL'S FINANCIAL RESPONSIBILITY I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.

In the event that my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided.

If I am uninsured, I agree to pay for the medical services rendered at the time of service.

\_\_\_\_\_  
**Signature of Patient-Authorized Representative/Responsible Party**

\_\_\_\_\_  
**Signature Date**

\_\_\_\_\_  
**Print Name of Patient Responsible Party**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Print Child's Name**

\_\_\_\_\_  
**Child's Date of Birth**