Pittsboro Pediatric Psychology & ADHD Clinic

Patient Acknowledgment Form:
Services Not Covered by Insurance

Client Name:_____ Date of Birth:_____

I request that the following service(s) be performed by Heather Brewis Scheffler, PhD. I understand that this/these service(s) may not be covered by my insurance company. I agree to pay any and all charges for these services. I understand that if actual charges are to exceed estimated charges by more than 10%, Dr. Scheffler must have me acknowledge, consent to, and initial these changes.

Service (s)	Estimated Charge (s)	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Signature of patient/client Date

_____ _____
Signature of parent, guardian, or authorized representative Witness

P.O. Box 1372 Pittsboro, NC 27312 Mobile/Office (919) 548-5612 Fax (919) 535-9247