PEDIATRIC EYE CARE & SURGERY
Sarah J. Whang, M.D.

FINANCIAL POLICY FOR CASH PATIENTS

Child's Name:_____ **Child's DOB**:_____

_____ I understand that Dr. Whang will not bill any insurance plan (i.e. Medi-Cal, Medi-Cal managed care plans, Medicare, private insurance or any other insurance) for my child's care today.
Initials

_____ I certify that my child is not enrolled in Medi-Cal.
Initials

_____ I certify that my child does not have a pending application for Medi-Cal.
Initials

_____ I agree to pay for today's services in full prior to leaving the office.
Initials

I certify that I have read and fully understand and accept the above financial policy.

Signature of Responsible Party: _____

Please print Name of Responsible Party: _____

Relationship to Patient: _____Date Completed: _____