CAPE COD PEDIATRICS
55 RT 130
PO BOX 549
FORESTDALE MA 02644

(508) 477-5306 (508) 477-0297

TO: Cape Cod Pediatrics

FROM: _____(Print Parent/Guardian Name)

DATE: _____

I acknowledge my child, _____, is over 18 years of age. I confirm that I remain financially responsible for all unpaid balances that may occur now and in the future. I understand it is my responsibility to notify you in writing when that financial agreement changes. Otherwise, I agree to make payments as required.

_____
Signed