Non-Covered Services Waiver

Patient name: ______________________________ DOB:________________

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NON-COVERED SERVICES STATEMENT: If you have any questions about whether or not a particular service is covered by your insurance, or the amount of services being rendered, please contact your insurance company. Depending on your health benefits contract there may be some services which may not be covered by your insurance. You will be expected to pay for these services in full following notification from your insurance carrier. As your child's provider, we will order only the test(s) and treatment(s) that we feel are necessary for your child's care.

MEDICAID: I understand that if I do not have a Medicaid referral from my assigned PCP on the date of service, I will be responsible for any changes incurred.

EXAMPLES OF POSSIBLE NON-COVERED SERVICES FOR PREVENTATIVE (ROUTINE) CARE WHICH MAY BE PROVIDED TODAY BY YOUR PHYSICIAN AND/OR ACTON ROAD PEDIATRICS STAFF ARE LISTED BELOW:

- **PHYSICIAN SERVICE:** Preventative care physician fee (well child visit), hearing and vision screening. (Additional treatments: Issues addressed during a routine visit that would constitute an additional office visit charge.)
- **LABS:** CBC, hematocrit, blood draw fee, urinalysis, and cholesterol levels.
- **VACCINES:** Vaccines, vaccine administration, antibiotic injections.
- **OTHER:** Allergy testing including lab charges, developmental testing and any other possible non-covered services.

I have read this policy and agree to pay for all rendered services, including those listed above, and those that are not covered by my insurance contract as indicated by my signature for each visit my child incurs.

1. CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, her associates and/or assistants.
2. I have reviewed the Policy and Procedures for Acton Road Pediatrics, LLC and agree to the **NO SHOW/CANCELLATION POLICY** which carries a fee of $25.00.
3. I understand that there will be a fee for form completion, immunization records and copies of medical records.

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Patient/Parent/Guardian Signature Date