Commercial Insurance Waiver

PATIENT NAME: _________________________________ DATE OF BIRTH ______________________

DATE: ____

In many cases, your insurance company may not pay for a service due to limitations of your policy. If your Insurance Company does not pay for a service, you will be financially responsible for the payment of that service. Your insurance company may deny payment on certain services done on a PHYSICAL EXAM VISIT because of your policy limitations or contracting. If your insurance company denies payment for any services rendered, you will be personally and fully responsible for payment.

On the physical exam we follow the guidelines recommended by the American Academy of Pediatrics. If you should bring in your own form, we will follow the requirements of that form. The purpose of this form is to help make you aware that certain services may not be covered, and that you may have to pay for them ... i.e. urine -$15, cbc -$45, vision -$15, hearing -$25, and other various vaccines.

Please circle:

YES: I want my child to receive these services.

NO: I have decided not to have my child receive these services.

SIGNATURE OF PARENT OR GUARDIAN: ____

NOTE: Your health information will be kept confidential. Any information that we collect about you or your child on this form will be kept confidential in our office. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your health information which your insurance company sees will be kept confidential.