

**PEDIATRIC ASSOCIATES
200 SOUTH ENOTA DRIVE
SUITE 150
GAINESVILLE, GA. 30501
PHONE (770)534-5255 FAX (770)287-3871**

Date: _____

Patient Name(s): _____

DOB: _____

The services listed below may be provided by Pediatric Associates, and may not be covered by your insurance provider. I understand that I will be responsible for the services rendered. This also includes Hearing and Vision Screenings.

We are unable to verify coverage on all patients; therefore it is your responsibility to check with your insurance carrier to determine if the services are covered. We cannot bill you at government cost for immunizations once a claim has been filed to your insurance carrier.

IMMUNIZATIONS:

_____ I have no insurance to pay for immunizations.

_____ My insurance pays for immunizations

_____ I have insurance, but it does NOT pay for immunizations

_____ I have Medicaid/Peachcare

_____ I request a copy of the 3231 Immunization Form

I hereby give consent for immunizations to be administered to my child today.

You will be provided with an information packet regarding immunizations administered today.

PARENT/GUARDIAN SIGNATURE: _____

WITNESS: _____