Date: ___________________________ Acct #: ___________________________

Patient Name(s): ____

DOB: ___________________________

PEDIATRIC ASSOCIATES

The services listed below may be provided by Pediatric Associates, and may not be covered by your insurance carrier. I understand that **I will be responsible for the services rendered**. This includes but is not limited to Hearing and Vision Screenings, Fluoride Varnish, Ages & Stages, and Vanderbilt forms**.**

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.

IMMUNIZATIONS:

1._____ I have **NO** insurance to pay for immunizations

2. _____ I have Medicaid/Peachcare/Wellcare/Amerigroup/Peachstate/Caresource

3. _____ My insurance pays for immunizations

4. _____ I have Tricare

5. _____ I have Medi-Share

6. _____ My Insurance does **NOT** cover preventative services

7. _____ I request a copy of an updated 3231

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

Please be aware that we are now required to do hearing and vision screens at the ages of 3, 4, 5, 6, 8, 10, 12, 15 and 18yrs. Your insurance carrier may or may not cover the hearing and/or vision screen. Please be aware that you will be responsible for the $20.00 charge for the hearing screen and also $20.00 for the vision screen if it is not a covered service.

There will be a $10.00 charge for Fluoride Varnish if it is not a covered service. This will be performed at 9mos, 15mos, 24mos, 30mos, and 36mos.

I hereby give consent for immunizations to be administered to my child today and/or have the hearing and/or vision screening and/or Fluoride Varnish completed.

_________ I decline to have the Hearing and/or Vision screen or Fluoride varnish completed at this time.

Parent/Guardian Signature: ____

Witness: ____