Northside Pediatrics, PC
Pediatric and Adolescent Medicine

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INSURANCE NON-COVERED SERVICES

Dear Parent or Guardian:

Insurance regulations suggest that I inform you in advance if I believe a service may not be covered or fully reimbursed by your insurance company. It is my professional judgment that all services, lab tests and vaccines that are ordered are needed in order to give you quality care. All of these services may not be reimbursed by your insurance company. Each insurance company has it's own formula for allowing and approving testing and each plan varies on which, if any, immunizations are covered. It is impossible to know each company's guidelines. It is *YOUR RESPONSIBLITY* to know if vaccines are covered under your particular policy.

Patient Agreement:

I, the parent or guardian of _____, certify that I have read and fully understand the above information. I understand that I am personally responsible for any charges not covered by insurance.

Parent or Guardian Signature_____ Date_____

Witness_____ Date_____