Northside Pediatrics, PC
Pediatric and Adolescent Medicine

INSURANCE NON-COVERED SERVICES

Dear Parent or Guardian:

Insurance regulations suggest that we inform you if we believe a service may not be covered or fully reimbursed by your insurance company. It is our professional judgment that all services, lab tests and vaccines that are done in our office are needed in order to give you quality medical care. Each insurance company has its own criteria for allowing or approving testing and each plan varies on which, if any, immunizations are covered. It is impossible for us to know each insurance company's guidelines. It is *YOUR RESPONSIBILITY* to know which tests and vaccines are allowed 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/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____