**Thank you for choosing All About Children Pediatrics.**

**If your child is being evaluated for a Physical, Preventative or Well Visit exam, please know we appreciate your trust in us to take care of all of your child’s health care needs.**

**We have contacted your insurance carrier to determine the benefits which your policy may or may not cover during this exam. Preventative benefits, as outlined by your insurance plan may not cover any separate medical discussion, request for medication refills and/or treatment of other health care concerns or procedures, if conducted at the same time as your Preventative, Well Visit or Physical. In the event of other care of treatment outside your normal Preventative benefits, you may incur office visit copay or be responsible for your deductible/co-insurance amount, based on your insurance benefits. You will be expected to pay your applicable portion at the time of service.**

**If you do not wish to incur separate billing for those extra services provided during your Physical, Preventative or Well Visit exam, please advise the front office staff, medical assistant and/or the physician prior to services being rendered. We will assist you in making a separate appointment in order to address additional issues/concerns.**

**\*\*\*I have been notified in writing and have been offered a copy of this notice. My signature acknowledges that I understand I am financially responsible for charges for all services not covered by me insurance during this Physical, Preventative or Well Visit exam\*\*\***

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**Patient Name (please print) DOB:**

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**Patient Signature Date:**