



**HIPAA Acknowledgement:**

I have received the Notice of Privacy Practice, and I have been provided an opportunity to review it.

**Policy Regarding "Well" Child Check-Ups**

Well Child Check-Ups/Physicals will be billed as such to your insurance plan. Insurance companies may also refer to this as **PREVENTATIVE CARE** or **ROUTINE EXAM**.

Due to coding laws, we **MUST bill your WELL CHILD CHECK-UP** with a Preventative Care code. If, during your visit you have **ADDITIONAL CONCERNS** or **PROBLEMS** that are not classified as "preventative" and require a separate diagnosis and/or other treatment, this would then be considered separate from your preventative care and may incur additional office or lab charges. All applicable charges will be billed to your insurance company. If you would like to keep these visits separate, we would be happy to schedule another appointment for a different date.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate as "patient responsibility."

Your child's Well Exam is important whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about your family's coverage. There are many plans and your benefits can change often. We will be happy to answer any questions that we can. However, we will not directly know the provisions of your specific plan.

**NOTE:** Certain tests we order as part of your **Well Child Check-Up** may or may not be covered by your insurance. This includes, but is not limited to, blood work, lab tests and x-rays. If your insurance uses a particular lab, please make the nursing staff aware of this once in the exam room.

We appreciate your understanding and cooperation.

***I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility."***

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature