WAIVER for NON-COVERED CHARGES

We pride ourselves on providing only the **highest quality care** for your child and do this by following many of the American Academy of Pediatrics clinical guidelines and other trusted sources for evidenced-based clinical outcome information.

However, insurers rarely keep pace with guidelines, or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests and non-covered services as we, your trusted providers of care, deem necessary.

Following is a list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Vision Screening

- **Snellen Testing.** This is a simple screening performed with the use of a Snellen eye chart used to measure visual acuity on older children.
- **Visual Evoked Potential** testing (or VEP). This is an important test for early detection of eye and vision problems in infants and young children. Amblyopia (or 'lazy eye') occurs when the brain does not receive proper images from the eye. If it is not diagnosed in early childhood, there may be a permanent loss of vision in the affected eye.

  As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount. For Snellen tests the discounted price is only $15.00, and for VEP tests the discounted price is $30.00.

Otoacoustic Emissions testing (or OAE)

This is an important hearing test and can be used on newborns through adulthood. It does not require a soundproof room or the ability of the child to understand instructions or respond to sounds, which makes it a much more accurate screening tool for picking up on hearing issues at any age.

Not only do we believe that hearing screens should be performed every year, but testing is required for most preschools, public and private schools, and for sports. As we consider this to be an important test for your child, and will routinely perform it at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $15.00 per test.

Developmental Testing

Developmental screening (including standard pediatric developmental screening done at well-visits, Connors forms, Edinburgh post-partum depression screening, etc) are very important in the assessment of any development delays or potential problems. As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $10.00 per test.

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In-office lab tests

Often, patients want to know as soon as possible if their child has the flu, strep, etc. We can effectively and efficiently determine that by performing in-office testing. Many insurers do not pay for in-office testing because they have contracts with external labs to provide these services. However, sending tests out to external labs results in waiting days for results that we can provide to you much more quickly (in some cases, within minutes or overnight). We believe it is important to treat your child as quickly as possible, and therefore offer these services in-office.

In-office labs and fees include:

In-office Test	Fee
RSV Test	$25.00
Rapid Flu	$25.00
Rapid Strep	$10.00
Urinalysis	$10.00
Pregnancy Test	$10.00

Please sign the following waiver indicating that you are aware that these charges may apply in the event that your insurance company does not cover these services.

Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge as stated herein, in the event that my insurer does pay for these services.

_____ _____/_____/_____

Patient/Responsible Party Signature Date

CHILD's NAME: _____ DOB: _____

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