NORTHWEST PEDIATRICS INC.

Date: _____ ACCT#: _____

Patient Name: _____ Patient DOB: _____

NON-COVERED SERVICES AUTHORIZATION AND WAIVER

Your insurance company may not pay for certain services. The physician may order an item or service based on their clinical expertise and your child's medical needs. If an item or service is not covered, you may be responsible for the cost.

Listed below are the most common non-covered services:

- Rapid Strep Tests
- Ear Irrigations
- Urinalysis
- Vision Tests
- Hearing Tests
- Flu Vaccines
- Pregnancy Test
- Lab Tests
- Sick and Well Visits on the Same Day
- More than One Well Child Visit within a Year
- Nutritional Therapy
- Mental Health
- Certain Surgical Procedures
- Spirometry
- EKG
- Other _____

This list is not inclusive nor does it mean that only these services will or will not be covered. Insurance policies vary in the benefits offered and you need to contact your insurance company regarding specific services covered by your policy.

I understand that you may bill me for non-covered services and I may have to pay the bill while my insurance company is making its final decision. If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment.

_____ _____
Parent/Legal Guardian Date

❑ **I Refuse the above**

_____ _____
Parent/Legal Guardian Date