



4986 N Adams Rd, Suite B
Oakland Township, MI 48306
Tel: (248)-609-1800
Fax: (248)-278-4977

Waiver

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.

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.

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

Ear Piercing

In addition to screenings and lab test, we also offer ear piercing which is not a covered service by your insurance company. We charge \$100 including a pair of studs.

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.



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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(s) Name [please list all in family]:

Guarantor / Responsible Party's Name:

Guarantor / Responsible Party's Signature:

Date: ____ / ____ / ____

Thank you