Julius Sherwinter, M.D.
A. Gerald Reisman, M.D.
Terrence Gfroerer, M.D.
Linda S. Kelly, M.D.
Samantha Nowak, P.A.

DUNWOODY PEDIATRICS

Gloria Ana Berenson, M.D.
Kelly Wilburn, M.D.
Mustafa Quraishi, M.D.
Kathryn Bland, C.N.P.

NOTICE OF NON-COVERED SERVICES

Notice to Parent/Patient:

A **WELL CHECK** has been requested today by you for your child prior to their birthdate or last annual physical. Your Insurance company my deny payment of this service if it does not fall within their **WELL CHECK** guidelines. We will file your claim to any Insurance company with whom we participate; however, if your Insurance company denies payment, we will bill you directly for this service.

Parent/Patients Acknowledgement and Agreement to Pay:

My Physician has informed me that he/she believes my insurance carrier may deny payment for the service identified in the ***NON-EXCLUSIVE*** list. ***If payment is denied, I understand and agree that it will be my responsibility to pay Dunwoody Pediatrics for the service***.

_____ _____

Parent/Guardian/Patient Signature Date

_____

Print Patient Name