Waiver

Dr. Almond and staff at *All Starr Pediatrics, LLC* are committed to providing only the **highest quality care** for your child. We utilize current suggested guidelines created by the American Academy of Pediatrics and other trusted sources for evidenced-based clinical outcome information.

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.

Examples of Screening Services include but are not limited to:

- Hemoglobin, Lead, Cholesterol Screening
- Vision tests
- Hearing screening
- Developmental screening
- Mental health questionnaires
- Adolescent questionnaire
- Autism Screening (MCHAT)

*** all laboratory, radiology and /or pathology services performed or referred by our providers may result in additional bills and/or charges from other companies that may include but are not limited to : Quest/Labcorp, Outpatient Imaging/Piedmont Fayette Hospital etc. You may receive separate billing statements for these services.*

This pediatric medical practice is committed to providing the most up to date, comprehensive care possible, which is why we address these issues at recommended or indicated visits. Further, we will strive to eliminate the need for the patient to return to the office, whenever possible. ***It is the responsibility of the policy holder to be aware of their insurance plan's benefits and coverage. Deductible, copay, coinsurance or out of pocket expenses agreed upon between you and your insurance company are out of our control.***

ALL STARR PEDIATRICS

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!