The Kidz Docs
Pediatric &
Adolescent Medicine

675 N. Washington St., Ste 490, Alexandria, VA 22314
(703) 765-6093(ph) (703) 765-7761 (fax)
www.TheKidzDocs.com email: patientinfo@thekidzdocs.com

Waiver for COVID Vaccine Administration

Patient's Name: _____ DOB: _____

Your insurance may not pay for all your healthcare costs. Some items and services may not be considered "covered benefits" under your health insurance plan and as such, your insurance may not pay for these services. Your provider believes that the following service, while they may not be covered by your health insurance, are an important part of your care and recommends that you receive these services. However, since the services may not be a covered benefit under your health insurance, should you choose to receive these services, you will be personally responsible for the payment of such services.

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services.

I acknowledge that I have been informed in advance of receiving this service and it may not be covered by my health insurance plan. I have chosen to receive this service and understand that I will be financially responsible.

Name of Parent or Legal Guardian (if applicable): _____

Signature of Patient or Parent/Legal Guardian (if a minor patient): _____

Date_____

This form must be signed by the patient or parent/legal guardian PRIOR to receiving services and must be maintained in the patient's medical record.