Insurance Waiver for Billing and Payment

Serenity Pediatrics and staff 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 evidence-based clinical outcome information.

Some insurances do not pay for all of the healthcare costs. Some items and services are not considered “covered benefits” under some health insurance plans. Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance are your responsibility. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware before specimens are sent out.

All co-payments, deductibles and non-covered services must be paid in full at the time of service.

Here is a list of some non-covered services:

CBC-Complete Blood Count, Rapid Strep, Rapid Flu, U/A Urinalysis, Mono Testing, Lead Testing, Lipid Profile, RSV Test, Hearing, Vision, Developmental Screening

Test received today_____

As a patient, you are required to have an active billable Insurance policy to include correct PCP (if it is required from the insurance), active coverage on dates of services that are rendered. To have correct personal information with insurance matching what is on file here at Serenity to include but not limited to date of birth, name and social security number.

Insurances correction_____

By signing below, I acknowledge that I have been informed in advance of receiving these services, that they may not be covered by my health insurance plan or that I may have corrections to make on my insurance plan in order to make it billable. I have chosen to receive these services and understand that I be financially responsible charges today for any reason within this waiver.

Print Patient Name _____

Name of Parent or Legal Guardian (if applicable)

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Signature of Parent or Legal Guardian (if applicable)

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Date_____

***This form must be signed by the patient or legal guardian over the age of 18 PRIOR to receiving services and must be maintained in the patient's medical record.**