



Preventative Care Services & Immunization Policy Consent

Your child or teen is scheduled today for a preventative wellness visit, sometimes referred to as a well child visit or physical. This visit is specifically defined by your insurance company to cover only a limited number of routine topics related to your child's growth, development, preventative screenings and vaccinations. **Your insurance company - not your provider - determines what counts as preventative care. We're required to bill for all services provided during your visit.** If we address non-preventative concerns, this may result in additional costs, as determined by your insurance company.

What's included:

- Review of current health and medical history
- AAP recommended age and risk-appropriate screenings and exam
 - Including but not limited to: SDOH, Edinburgh, MCHAT, SWYC, PHW, CRAFFT-N, etc.
 - Note: some insurances put screenings to a small patient balance
- Universal screening labs and immunizations
- General health counseling and recommendations related to preventative health

What may result in additional cost:

- Chronic health conditions (e.g.: ADHD, diabetes, short stature, food allergies, eczema)
- New or worsening symptoms (e.g. jaundice, picky eating, constipation, pain, rash, depression)
- Diagnostic tests (labs or imaging) or referrals for new or ongoing issues
- Minor procedures
- Travel health services
- Any services your insurance doesn't consider preventative

If we discuss or address any of the above during your preventative care visits, your insurance may apply extra fees (copay, deductible, or coinsurance) and it may apply differently than a typical, separate office visit.

Please note: Your insurance company - not your provider - determines what counts as preventative care. We're required to bill for all services provided during your visit.

Immunizations: Once verbal consent for a vaccine has been obtained by the provider and the vaccine has been ordered and prepared for administration, if you then change your mind and refuse the vaccine, **you will be financially responsible for the cost of the vaccine** as it cannot be returned to our stock after it is prepared. The amount due will be collected on the date of service.

I acknowledge and understand the information above regarding combining routine preventative visits (well visits) with office visits where problems or concerns are addressed.

Patient Name: _____ Patient DOB: _____

Parent/Guardian Signature: _____ Today's Date: _____

Parent/Guardian Printed Name: _____ rev 9/2026