PEDIATRIC ASSOCIATES OF WATERTOWN, P.C. WAIVER FORM FOR:

**Non-Covered Services*
**Not Medically Necessary Services*

PROVIDER INFORMATION:

PEDIATRIC ASSOCIATES OF WATERTOWN, P.C. (315)782-4391

PATIENT INFORMATION:

Patient Name:____ Pt DOB: _____/_____/_____
Gender: _____ MALE ______FEMALE

WAIVER FORM STATEMENT:

The purpose of this waiver form is to inform patients and/or parents/guardians/entrusted adults of Pediatric Associates of Watertown, before they receive a medical service, that the service circled below from the list of services may be non covered or deemed not medically necessary by their insurance company. By signing below, the patient or adult entrusted for care of the patient is aware of and agrees to pay for the charges for the services if the insurance does not cover them.

I have been informed by Pediatric Associates of Watertown, P.C. in advance that the service(s) circled below are services that may not be covered by my health insurance plan. I understand and agree that I am responsible for payment of the provider's charges for these services to Pediatric Associates of Watertown, P.C. In the event that I am not the Responsible Party for this patient account, I confirm that I have the authority from the Responsible Party to agree to these conditions.

Patient/Parent Signature:____________________________________ Date:__________________
Signer's Written Name:______________________________________
Relationship to Patient:______________________________________

SERVICES TO BE PROVIDED	**COST**
Fluoride Varnish Application	$30.00
Hearing Test (EOE: Evoked Otoacoustic Evaluation)	$75.00
Developmental Testing/Evaluation	$53.00
Emotional/Behavioral Assessment	$70.00