CONSENT AND FINANCIAL POLICY

PATIENT'S NAME: ______________________________ DATE OF BIRTH: ______________

WELL CHILD EXAM/ROUTINE PHYSICAL – HEALTHY CHILD <u>WITHOUT</u> SYMPTOMS

- **Includes:**
  - **Immunizations**
  - **Monitoring growth and development**
  - **Give advice on healthy behavior**
  - **Discuss preventive steps to promote good health**
  - **Vision and hearing**
- **<u>NOT</u> included: subject to copay or deductible**
  - **Abnormal findings**
  - **New disease/condition/symptoms**
  - **Management of chronic disease/conditions**
  - **Medications for illness**
  - **Medication refills**
  - **Daycare/school clearance**
  - **Sport/camp physicals**
  - **Referrals to specialists/therapies**
  - **In-office labs/procedures**
  - **Follow-up visits**

<u>I acknowledge that I may ask my provider to evaluate and manage my medical problem(s) during my preventive WELL EXAM and that the treatment will result in a separate office visit to be billed in addition to the preventive WELL EXAM.</u>

______________________________ ______________________

Parent/Guardian Signature **Date**

______________________________ ______________________

Parent/Guardian Printed Name **Relationship to Patient**