



# THE PEDIATRICIANS OF HYDE PARK

## SERVICES THAT MAY OR MAY NOT BE COVERED BY INSURANCE

\_\_\_\_\_  
Patient name:

\_\_\_\_\_  
DOB:

I, \_\_\_\_\_ understand that the services and or supplies listed below may not be considered eligible for benefits (e.g. services and or supplies may be determined to be not medically necessary, non-covered, applied to deductible or investigational by your health insurance). I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and or supplies. Since I have chose to obtain the services and or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Non-covered services include:

| PROCEDURE:                      | PRICE:  |
|---------------------------------|---------|
| Pedi-Vision (test)              | \$25.00 |
| Vision (test)                   | \$20.00 |
| Pure Tone (hearing test)        | \$35.00 |
| OAE (hearing test)              | \$35.00 |
| ASQ or MCHAT (development test) | \$25.00 |
| Craft (screening)               | \$10.00 |
| PHQ or Vanderbilt (screening)   | \$10.00 |
| Edinburgh (screening)           | \$10.00 |
| Fluoride Varnish                | \$35.00 |
| Nutrition Counseling            | \$10.00 |
| Lipid Profile                   | \$70.00 |

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date:

KATHLEEN LAMPING-ARAR, MD, F.A.A.P.  
ALISSA M. GILBERT, MD, F.A. A.P.

EDWARD R. GARVIN, MD, F.A.A.P.  
KARRY R. WILKES, MD.F.A.A.P,

ALYSSA PILJAN-GENTLE, MD, F.A.A.P.  
SHANNON GOLDEN, MD. F.A.A.P.