

Cornerstone Pediatrics
ADVANCED BENEFICIARY NOTICE FOR
LABS & OTHER PROCEDURES

Patient's Name: _____ Patient's Date of Birth: ____/____/____

Vision Screening:

Our office offers the most technologically advanced and accurate binocular (both eyes) vision-screening device. This device uses state-of-the-art photo screening with infrared computerized technology.

It is safe for your child, non-invasive and requires no direct hands on contact with your child. Infants and small children may sit in your lap during the procedure. There is no need for eye drops, only takes seconds to perform and can help detect potentially blinding eye diseases.

In-Office Labs and Procedures:

To aid in this process of expediting lab results needed by our physicians on acute visits Cornerstone Pediatrics now offers in-office labs as an added convenience to our patients. This convenient service will also save you time and reduce your cost on fuel spent traveling to another location for labs.

Non-Covered Benefits:

Some aspects of health care are covered by your health care service plan, however, others are not covered benefits and consequently your health plan may not pay for them. When you receive an item or service that is not a covered benefit, Cornerstone Pediatrics will charge the patient account for the service provided.

The purpose of this notice is to help you make an informed choice about whether or not you want the labs and procedures for your child, with the understanding that you may have to pay for this service yourself if your insurance provider denies the claim. Before you make a decision about your options, you should read this entire notice carefully.

PLEASE CIRCLE ONE (1) OPTION BELOW:

- YES – I choose to have in-office labs performed on my child.
- YES – I want to have a tympanogram performed on my child.
- YES – I desire for the PediaVision screening to be performed on my child.
- YES – I agree for _____ to be performed on my child.

NO – I choose not to have any of these services performed on my child at this time.

You are responsible for the usual co-payments and deductibles that are associated with covered services, and any fees associated with non-covered items and services. Our staff is able to give you a projected cost of the services being provided upon request.

BENEFICIARY AGREEMENT

Accordingly, the undersigned accepts full financial responsibility for procedures described above that may later be determined to be a non-covered service.

Print Name of Parent or Guardian

Signature of Parent or Guardian

Date

