Date: _____ **Acct #:** _____

Patient Name(s): _____

DOB: _____

PEDIATRIC ASSOCIATES

1485 Jesse Jewell Pkwy, Ste 200
Gainesville, GA 30501
(770) 534-5255

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Erol Onal, D.O., FAAP
Michael E. Hilton, M.D., FAAP
Heather D. Butler, M.D., FAAP
Kristi A. Kennedy, CPNP

The services listed below may be provided by Pediatric Associates, and may not be covered by your insurance provider. I understand that I will be responsible for the services rendered. This also includes Hearing and Vision Screenings.

We are unable to verify coverage on all patients: therefore it is your responsibility to check with your insurance carrier to determine if the services are covered. We cannot bill you at government cost for immunizations once a claim has been filed to your insurance carrier.

IMMUNIZATIONS:

_____ **I have no insurance to pay for immunizations**

_____ **My insurance pays for immunizations**

_____ **I have insurance, but it does NOT pay for immunizations**

_____ **I have Medicaid/Peachcare**

_____ **I request a copy of the 3231 Immunization Form**

I hereby give consent for immunizations to be administered to my child today.

You will be provided with an information packet regarding immunizations administered today.

PARENT/GUARDIAN SIGNATURE: _____

WITNESS: _____