Children's of Alabama

Mayfair Medical Group
3401 Independence Drive
Homewood, Al 35209
PHONE: (205) 870-1273
FAX: (205) 870-1276

NON – COVERED SERVICES STATEMENT & CONSENT FOR TREATMENT

As your child's provider, I want to provide my patient with the best care possible. There are services I feel are necessary for the treatment of your child's condition and maintenance of good health that may not be covered by your health benefits contract. Should your insurance not cover these services, you are expected to pay for those services in full.

Let me reassure you that I will order only the tests and treatments that I feel are necessary for your child's treatment and care.

If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree to pay for the services outlined below that are not covered by my contract as indicated by my signature for each date below.

POSSIBLE NON-COVERED SERVICES INCLUDES BUT NOT LIMITED TO THE FOLLOWING:
If your visit is for a check up and there is an illness, co-pays may apply
After Hour charges may apply
Walk in/ Emergency charges may apply
Preventive Care
Developmental Screening Forms (ASQ-MCHAT) & ADD/ADHD Questionnaire Forms
Hearing/Vision Screening
Urinalysis
Hematocrit/CBC/Blood draw
Vaccines
Medical & Orthopedic Supplies
Other: _____

_____

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants.

Signature: _____ Date: _____

Parent / Guardian
(Financially responsible party)

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Consent for Medical Treatment of a Minor Child

When you are away from your child, the person entrusted with your child's care may be faced with an illness or injury to your child that cannot be treated promptly until your consent has been obtained. If you would like to give permission to your child's caretaker, or someone other than yourself to seek medical care in your absence, please complete the following form:

I_____give permission to_____

_____

_____

To seek medical attention for _____D.O.B. _____

To seek medical attention for _____D.O.B. _____

To seek medical attention for _____D.O.B. _____

To seek medical attention for _____D.O.B. _____

at Mayfair Medical Group. This permission will be valid for:

1) the duration of enrollment at Mayfair Medical Group
2) from_____to_____

Signature of Parent or Guardian_____Date_____

Signature of Witness_____Date_____

Consent to Discuss Financial Information

Unless we have written permission we will not discuss financial information with anyone other than the person responsible for the account as per our financial policy. If there is anyone who has your permission to discuss this information with our insurance and billing office, such as a care taker, a step parent or a grandparent, please list this person or person's below. **Please know that as always, the person who accompanies the patient is responsible for the bill or co-pay at time of visit.**

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Signature of Responsible Party	Date