# Waiver and Assignment of Benefits

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**Assignment of Benefits -** At White Cloud Pediatrics, all professional services rendered are charged to the patient and are due at the time of service unless insurance coverage is verified and White Cloud Pediatrics is a participating provider. Necessary forms will be completed to file insurance claims.

I hereby assign all medical benefits, including major medical benefits to which I am entitled, and authorize my insurance carrier(s) to issue payment directly to White Cloud Pediatrics for medical services provided to me and/or my dependents. I understand that I am financially responsible for any amount not covered by insurance.

## Authorization to Release Information

I authorize White Cloud Pediatrics to:

1. Release any necessary information to insurance carriers regarding my dependent's illness and treatments.
2. Process insurance claims generated during examination or treatment.
3. Use a photocopy of my signature for insurance claim processing.

I understand that by requesting medical services, I am financially responsible for all charges incurred, including copays, coinsurance, and deductibles. Fees are due on the date services are rendered.

## Waiver for Screenings, Tests, and Non-Covered Services

White Cloud Pediatrics follows American Academy of Pediatrics clinical guidelines to provide high-quality care. However, insurers may not cover all services related to these guidelines due to frequent policy changes.

To ensure timely and appropriate treatment, I authorize White Cloud Pediatrics to perform necessary screenings, tests, and non-covered services, even if these are not covered by my insurance. I accept financial responsibility for these services, which may include but are not limited to:

- Vision and hearing screenings
- Developmental and behavioral health screenings
- Preventive care visits, such as well-child exams and immunizations
- Vaccines not covered by insurance
- Laboratory tests (e.g., bloodwork, urinalysis)
- Mental health services
- Immunization or vaccine documentation for schools or daycare

**Waiver Consent -** I consent to the provision of any recommended screenings, tests, or non-covered services as part of my child's healthcare plan. I understand that I am responsible for payment for any services not covered by insurance.

Guarantor / Responsible Party's Signature: _____ Date: _____

Guarantor / Responsible Party's Name: _____