HEALTHY ROOTS
PEDIATRICS

Effective 12/01/2023

27 Hilliard St, Manchester, CT 06042

Office: 860.646.3903

Fax: 860.645.3492

Important Information about Your Preventative Visit**

Preventative visits are an important part of your overall health management plan. We encourage you to have a preventative visit according to the schedule and guidelines recommended by your provider and in accordance with the American Academy of Pediatrics guidelines.

In most cases, preventative visits* are covered by insurance. However, if you receive certain additional services during your visit, you may be responsible for an out-of-pocket cost such as a co-pay or deductible.

Services included in a preventative visit:

- A review of your medical history
- A physical exam
- Information about how to reduce risk factors that could affect your health
- Review and distribute laboratory tests according to age-appropriate guidelines
- Immunizations
- Age-related counseling to improve your overall health

Services that could lead to additional charges during your visit:

- Treatment/discussion of **new** concerns; *Examples, but not limited to*: Rash, cough, mental health, headaches, fatigue, constipation, abdominal pain, etc.
- Treatment/discussion of **existing** concerns; *Examples, but not limited to*: Asthma, mental health, ADHD, headaches, etc.
- Procedures such as ear cleaning or wart treatment
- Screenings such as hearing, vision, developmental and behavioral health, hemoglobin, lead, cholesterol and blood testing

Your health and wellness are our highest priorities. We look forward to providing you with the highest level of care and services to improve your health. Please ask your care team if you have any questions about preventative care and what may or may not be covered by your insurance.

☐ I understand that not all services I receive today or in the future may be covered by my insurance plan. Additional services, such as treatment of a new or existing condition or procedures performed at my request for my child or at the provider's recommendation, may result in an out-of-pocket cost to me depending on my insurance plan.

_____ _____

Parent /Guardian/Patient Signature ***Patient Name/Date of Birth***

_____ _____

Printed Name ***Date***

**All insurance plans are different. Please confirm your specific benefits with your employer, human resource professional, or health plan representative.*

***For our newborn patients and their parents/guardians, this applies to all well child visits in your child's first year of life.*