Gilbert Pediatrics Well Care Policy

Good health care for newborns, infants, children and adolescents includes regular well-child visits (checkups). Checkups focus on *preventive* services. We provide services at checkups based on recommendations from the American Academy of Pediatrics (AAP), which include:

- Physical examinations
- Screenings
- Assessments
- Advice about health and safety.

We also follow the AAP vaccination schedule for newborns, infants, children and adolescents

While most insurances cover *specific preventive services* without a cost to the patient, some do not. For this reason, **we ask that you know your benefits and verify which services are covered by your insurance plan.**

Examples of these services include (*but are not limited to)*:

- MCHAT (Modified Checklist for Autism in Toddlers)
- Vision Screening
- Iron check (hematocrit)
- Vaccine product and administration

Well Care vs. Problem-Oriented Care

If a child is not well or a problem is found during the checkup that needs to be addressed, we may need to provide an additional office visit service. If your health plan requires a co-payment, coinsurance, or a deductible for these non-checkup services, you will be responsible for these amounts.

Examples of these services include (*but are not limited to):*

- Work that addresses more than a minor problem (i.e., prescription, orders or tests to address acute or chronic medical conditions; or changes in care for a known health problem)
- Medical treatments (i.e., breathing treatments)
- Any surgery (i.e., removing splinters or something the child put in his nose or ear)

We value your time and want to make the most of each appointment. This is why we try to address any problem that needs care during well-child visits so that only one trip is needed. However, in some cases, such as when the additional service is not urgent and will interfere with other patients' appointments, **you may be asked to schedule another appointment**.

Acknowledgment: I have read the above policy, and am aware that during my child's well visit there may be additional services provided that may result in copay, coinsurance or deductible costs that I am responsible for. I also understand that I may choose to return for a separate visit to address concerns that may not be considered part of the well checkup.

Child(ren)'s Name: _____

Parent/guardian signature: _____Date: _____