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FORM #7

Preventive Visit Charges

Austin Regional Clinic works hard to give the highest quality care by providing yearly physical examinations. Most insurance companies cover one wellness exam per year at no cost to the patient, including certain tests to detect disease in early stages or to prevent disease.

Unfortunately, most insurance companies **will not cover** services unrelated to the physical and can choose to not cover the full cost of the office visit for separate health concerns discussed during an exam:

- Addressing new or ongoing health problems (e.g., blood pressure, rash, acne, back pain)
- In-office procedures (e.g., wart destruction, toenail removal, ear wax removal)
- Laboratory tests for illness, injury or chronic conditions
- Frequency of Laboratory test

Some examples of services or discussions that **may not be covered** in a physical examination:

- Non-scheduled, but necessary immunizations (TB tests needed for work, etc.)
- ***Your doctor may recommend routine laboratory tests for health screening (like cholesterol, thyroid, complete blood count). However, your insurance plan may not cover these tests or may consider them as part of your deductible, and you may be billed for them.***
- Pathology or Pap tests not considered routine by your insurance
- Tests that are not normally needed due to a patient's age or health risk

Each insurance company decides what will be paid on a case-by-case basis, and decisions made cannot be predetermined by ARC**. If you have questions about what is covered under your health insurance plan for routine physicals or wellness exams, please contact your insurance company or your Human Resources Department.**

Any charges not considered as part of a routine physical or wellness exam will be billed separately and any items or services not covered will be billed to the patient.

Austin Regional Clinic apologizes for this inconvenience and appreciates your understanding that we must follow the insurance company billing guidelines in order to submit claims on behalf of our patients.

Please acknowledge:

I understand I may be responsible for any item(s) or service(s) that my insurance company may determine is not a part of a routine physical or wellness exam.

Patient Name (print): _____ MRN: _____

Patient/Guarantor Signature: _____ Date: _____