PHYSICAL AND IMMUNIZATION DISCLAIMER
HOSPITAL DRIVE PEDIATRICS

Patient's Name _____ ☐M ☐F DOB _____

- I choose to have my child be given a physical and/or immunizations BEFORE 365 DAYS have elapsed since the last physical.
- My insurance carrier may not cover any of the charges for this physical and/or immunizations.
- I understand that Hospital Drive Pediatrics will bill my insurance as usual.
- I am fully responsible for paying ALL charges not covered by my insurance plan.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____