Anderson Hills PEDIATRICS

At Anderson Hills Pediatrics, we are offering the Moderna COVID-19 vaccine to our patients.

Your insurance provider may not fully cover the cost of the vaccine or associated services. This notice is to inform you that you may be responsible for some or all of these costs if your insurance company denies payment.

Below are the estimated costs if you choose to participate in our Prompt Payment Plan, which requires either:

- A credit card on file, or
- A $100 deposit at the time of service.

| Service | CPT Code | Estimated Cost |
|---|---|---|
| Vaccine (6 months – 11 years old) | 91321 | $200.00 |
| **OR** | | |
| Vaccine (12 years and older) | 91322 | $200.00 |
| **AND** | | |
| Administration of Vaccine | 90480 | $50.00 |

The vaccine administration cost covers the work our team does to safely give your child a vaccine. This includes storing and handling the vaccine properly, preparing the dose, confirming it's the right vaccine for your child, giving the shot, documenting it in their medical record, and monitoring for any immediate reactions.

If you choose *not to participate* in the Prompt Payment Plan, you will be responsible for paying the full amount allowed by your insurance company. *Final costs may vary depending on your insurance coverage and negotiated rates may be higher than listed above.*

Should you make a $100 deposit and your insurance cover the cost of the vaccine in full or at any amount that requires a refund, we will process this automatically to the card used for the original payment.

We will bill your insurance for all services provided. Please note:

- The CPT codes listed above are provided as a general guide.
- Costs and coverage may vary depending on your specific insurance plan and clinical circumstances.
- Your insurance company may cover all, part, or none of these services.

**Patient Acknowledgment of Financial Responsibility**

Please read and initial each statement:
_____ I understand that my insurance provider may not cover the full cost of the vaccine or related services.
_____ I understand these are estimated costs, and the final billed amount may differ based on insurance reimbursement.
_____ I agree to be financially responsible for any portion of the cost not covered by my insurance.

_____
Printed Name

_____
Patient Name

_____
Signature

_____
Patient Date of Birth

_____
Date