ALL STAR PEDIATRICS, INC.
INFANTS, CHILDREN, TEENS
4995 49th Street North St. Petersburg, FL 33709-5901
(727) 525-7852 Fax: (727) 527-0548

Gardasil Vaccine (females ages 9-26 yrs)

Request
My signature below verifies that I have requested this vaccine for my female child:

Child's Name ______________________ DOB: ____________

VIS (vaccine information statement)
My signature below verifies that I have received a copy of the VIS for Gardasil as prepared by the CDC.

Payment Guarantee
I understand that if I have health insurance, my health insurance will be billed for the cost of the vaccine. I also understand that not all health plans are covering this vaccine. Therefore, I agree and commit that if my health plan does not cover this vaccine, I will pay $150.00 for each vaccine given (there are three vaccines in this series) to the office within 10 days of notification by the office. I understand that if my health plan does make a payment toward the vaccine, but if that payment does not cover the cost of the vaccine to the practice, I will be billed for the difference between the cost of the vaccine and the amount the health insurance plan pays. I specifically agree and understand that my signature to this statement is separate and distinct from any contractual language between my health plan and the practice.

I authorize the practice to utilize the following form of prepayment towards this guarantee (circle method and provide to receptionist):

- Cash deposit
- Check (may be post-dated up to 30 days)
- Credit Card imprint

Release & Consent
I have read the above information and consent to administration of this vaccination. My signature below verifies my consent for the vaccination to be administered.

______________________ ______________________
Signature Printed Name

____
Date