Patient Name:_____ Patient DOB:_____ Acct #:_____DOS_____

Capital Area Pediatrics – 30 Month Well Visit Services Authorization

The charge for today's office visit is listed below, along with the charges for additional services that may be recommended based on your child's age, risk factors, or health situation. Our medical staff will only perform and bill for those services that are due for YOUR child today. It is your responsibility to pay for any services that are not covered by your insurance. The billing (CPT) code can be found next to each service.

Preventative Medicine Office Visit:

New patient (99382) $210.00
Established patient (99392) $193.00
Dental Varnish (99188) $35.00 (If indicated)
Forms $10.00 each – ***not covered by insurance***

Immunizations:

Flu shot, Seasonal (90685) $35.00 + Vaccine Administration (90460) $47.00 = $82.00

Uninsured Patients: Vaccines will be provided to any *eligible* child 0 to 18 years old through the Virginia Vaccines for Children Program, but you will be charged the administration fee of $21.00 per vaccine.

Under-Insured Patients: (Plan does not cover well child services) you may elect to receive vaccines at reduced cost through your local health department.

Screenings:

SPOT PediaVision Ocular Screen (99174) $35.00 ***Not covered by some insurance plans**

Lab Tests: *if indicated or required*

Hemoglobin (85018) $9.00, Toe or Finger Stick (36416) $9.00 = $18.00
TST (TB Skin Test) (86580) $24.00 = $24.00
Lead (83655) $25.00, Toe or Finger Stick (36416) $9.00 = $34.00

Additional Services (Medical Procedures and Specific Health Conditions):

Sometimes a problem or abnormality is addressed (e.g. fever, severe skin conditions, or recurrent wheezing) which is outside of the scope of a well visit. When additional work is required at the well visit to address this type of issue, an additional office visit/sick visit code or procedure code will be reported to your insurance company. This may also include catch-up services not included in physical exam.
These services may be subject to cost sharing (co-pays and/ or deductibles) as determined by your insurance company.

Insurance eligibility status	**Insurance Plan:**	
	As of today's date, your insurance indicates that your coverage is ACTIVE.	
A problem has been identified with your insurance coverage:		
	CAP Providers are not participating with your plan.	If uninsured, a 20% discount is available for fees that are paid in full at time of service.
	Your insurance coverage is inactive or not on file	
	An eligibility issue has been identified (Name or DOB mismatch)	
	Services require a referral or authorization and one has not been obtained from your PCP	
	PCP not selected – (Required By Your Insurance)	
The financially responsible party will be liable for all charges rendered at today's visit if claims are denied and/or new insurance information is not supplied within 30 days of today's visit.		

I acknowledge that I have been given information and fees related to today's visit. Date: _____

PRINT: _____ SIGNATURE: _____

Name of Legally authorized patient/accompanying adult