Patient Name: _____ Patient DOB:_____ Acct# _____ Date: _____

Capital Area Pediatrics
your neighborhood pediatrician

FINANCIAL RESPONSIBILITY/INSURANCE INFORMATION:

The developmental/behavioral services that are provided by Dr. Polly Panitz is highly specialized and may or may not be covered by your medical or behavior healthcare insurance policy.

Prior to your appointment, we encourage you to contact your insurance provider to familiarize yourself with and have a discussion about your benefits. Some insurance companies may state that certain codes are covered; however until the bill is processed, it is not a guarantee of payment.

Below, are some of the reasons your policy may not cover our services:

- Our providers are credentialed primary care providers and may not meet the criteria as a Behavioral Health/Mental Health Care Provider.
- Your insurance policy may not cover the diagnostic code we give to your child at the time of the visit.
- Some insurance companies may not cover specific procedure codes. (see list below)
- Some insurance companies require a pre-authorization prior to the evaluation. Please advise us if this is your policy requirement.

Initial Developmental Behavioral Visit :

CPT CODE:	SERVICE	FEE
99245	Consultation- 1 hr. w/ Parents	**$400.00**
99215	Office Visit- level 5	**$207.00**
96116	Neurobehavioral Testing (typically 2 hours)** ($203.00/hr.)	**$406.00**

*Most insurance companies will only cover this service if provided Behavioral Health/Mental Healthcare credentialed provider.

Follow up Visits:

CPT CODE:	SERVICE	FEE
99245	Consultation- 1 hr. w/ Parents	**$400.00**
99215	Office Visit- level 5	**$207.00**
99214	Follow Up- and/or MEDICATION Check (**office visit- level 4**)	**$151.00**
99354	Prolong Service (after first hour)	**$137.00**
96110	Developmental Screening with Interpretation and report (**Not to exceed 3 tests**)	**$21.00 per test**

I understand the above information and am prepared to sign a service authorization at the time of my scheduled appointment agreeing to my financially responsibility. I understand that not all services may be covered by my insurance provider and I agree to pay for any fees that may include but are not limited to co-pays, deductibles or non-covered service.

Initial HERE_____