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

Capital Area Pediatrics
your neighborhood pediatrician

Authorization for Developmental Behavior Services, (Initial Parent Visit)

Polly Panitz, M.D.

The developmental and behavioral services that are provided by Dr. Polly Panitz is highly specialized and has limited availability in the Washington metropolitan area. Capital Area Pediatrics, Inc. (CAP) is happy that we can provide her services to our patients. Dr. Panitz is credentialed with those insurance companies, in which CAP participates. *Our providers are not credentialed as mental health specialist and all claims will be submitted as major medical health claims.*

CAP does not guarantee that services will be a covered benefit under your child's health plan. Coverage is based on diagnosis and services provided, which is determined after a claim is received and processed by the patient's insurance plan. The doctor will determine the diagnosis (es) at each visit and these will not be changed to meet the criteria of the specific healthcare plan. If you have concerns as to why a specific diagnosis is not covered, please address this question to a representative from the patient's insurance company. We will make every effort to inform the family of services expected to be performed, prior to services being rendered. This is to ensure that family is aware of the cost of care that they may ultimately be responsible for paying (see below regarding certain insurance criteria).

Service	CPT	FEE
Consultation - Comprehensive Exam (DBNP, DBR#1, DB90)	99245	$400

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. ☐ Your insurance coverage is inactive or not on file.. ☐ An eligibility issue has been identified (Name or DOB mismatch) ☐ PCP not selected – (Required by your insurance)
The financial 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 have read the above information and I understand that I will pay for services not covered by my insurance carrier, including but not limited to co-pays, deductibles and non-covered services.

Print: _____ **Signature:** _____ **Date:** _____

Witness: _____ **Date:** _____