

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



Authorization for Developmental Behavior Services (School Observation)

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This document will serve to clarify the process for a school observation. You and your clinician will determine if an observation of your child within his/her natural environment will add to the assessment process. Please understand that this service **will not be covered by your insurance** and therefore you will be financially responsible for the flat charge of **\$300.00***. By signing below, you agree to the school observation and assume the financial responsibility for the visit.

You will need to do the Following:

1. Sign and return the school observation consent to the Capital Area Pediatrics Herndon office, if not already completed. **Fax to 703-860-1528 - Attention: Sharon Milligan, LPN.**
2. Give the school contact person your permission to authorize the visit and to speak with our clinician.
3. Email the physician and your teacher to arrange for a time for the visit.
4. Once the visit has been scheduled, be certain you have a follow-up appointment with your Developmental Pediatrician to discuss the results of the school visit.
5. If your child is ill the day of the visit and the school visit needs to be cancelled, please call and email the school and the physician.

Name of School: _____

Service	CPT	FEE
School Visit (this service will not be submitted to your insurance)	N/A	\$300

I, _____, authorize the service to be performed within three months of signing.
(Please print name)

Accompanying Adult Signature (Authorized to provide consent for patient) Date:

Your relationship to the Child: _____

Witness: _____ Date: _____