Capital Area Pediatrics

Patient Chart #:

Capital Area Pediatrics - 1 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 (99381) - $201.00
Established patient (99391) - $180.00

Forms $15.00 each – ***not covered by insurance***
Evening/Saturday/Sunday/Holiday Add'l Charge (99051) $30.00

Immunizations:

Hepatitis B (90744) $40.25 + Vaccine Administration (90460) $47.00 = $87.25

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.

Lab Tests:

Newborn Metabolic Screen - *only if not performed in hospital or repeat test required*
(S3620) $53.00 if test kit purchased by CAP, Heel Stick (36416) $10.00 Lab Handling/Send Out (99000) $35.00 = $98.00
(S3620) $0.00 if test kit provided by Hospital, Heel stick (36416) $10.00 Lab Handling/Send Out (99000) $35.00 = $45.00

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.

Total Fees for Today's Visit:

	You do not have insurance coverage for today's visit
	A problem has been identified with your insurance coverage
	Services are not covered by your insurance
	Capital Area Pediatrics does not participate in your insurance plan
The financially responsible party will be liable for all charges rendered at today's visit. A 20% discount maybe applied to the total amount if paid in full at the time of service.	

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