Capital Area Pediatrics

Patient Chart #:

Capital Area Pediatrics - Preventative Medicine Services Authorization (Sports/Camp Clearance)

The physicians and staff at Capital Area Pediatrics are dedicated to providing your child with appropriate preventative care. Your child has already received an annual preventative service recommended for his/her age and is not yet due for another annual exam. However, you are requesting that the CAP providers complete a form required by a third party in order to participate in either a sport or camp program. This program requires a timely review of your child's health status. This service will not be billed with the usual well-child diagnosis but with a diagnosis code appropriate for this visit (Medical examination for administrative purposes). **This is not a covered service by your insurance. Below are the procedure code and the fees associated with this service. Payment will be required at today's visit.**

*99213 Evaluation and Management Service	$133.00
Forms	$ 15.00/each

***For sports clearance appointment only.**

***If there are additional concerns discussed during the visit, may be billed as 99214 ($196) or 99215 ($264) based on provider exam.**

Screenings: *If form indicates requirement*

Vision Screen, Conventional (99173) $7.00

or SPOT PediaVision (99174) $35.00 **– (Special needs only/unable to cooperate)**

Hearing Screen – Audio 3, (92551) $26.00

Lab Tests: *if indicated or required*

81002	Urinalysis	$ 9.00
85018/36416	Hemoglobin & finger stick	$19.00
86580	Tuberculin skin test	$25.00

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