| Patient Chart #: |
|---|

## Capital Area Pediatrics - Authorization for Travel Consult Services

The physicians and staff at Capital Area Pediatrics are dedicated to providing your child with the best possible healthcare outcomes. Capital Area Pediatrics, Inc. (CAP) provides travel consult services to review your child's health status prior to traveling. This service uses travel consult diagnosis code. This diagnosis code and the vaccines recommended for your travel are generally not covered by insurance and it is your responsibility to make payment in full.

*99212 Evaluation and Management Service $ 80.00

***A 20% discount is available for fees that are paid in full at the time of service**

**Vaccines recommended for travel:**

Typhoid (90691) $109.25 + Vaccine Administration (90460) $47.00 = $156.25
*MMR (90707) $110.40 + Vaccine Administration (90460) $47.00 & (90461) 2 units X $23 = $203.40
*HEP A (90633) $51.75 + Vaccine Administration (90460) $47.00 = $98.75

***As a courtesy, the MMR and HEP A vaccines recommended for your travel can be submitted to your insurance but there is no guarantee of payment. The MMR and HEP A vaccines will be processed by the insurance plan and any applicable discount will be taken based on the insurance contract. If your insurance denies vaccines, they will be patient responsibility and the 20% discount does not apply.**

***The vaccines are dependent on the area that you will be visiting and the age of your child**

| **Total Fees for Today's Visit:** |
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| |

| | |
|---|---|
| | 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**

*Revised June 01, 2024* CAP3028