

MOORE PEDIATRICS AND ASSOCIATES

With every well visit **4 years** and older we will perform a **vision** screen. We also screen **hearing** once before kindergarten starting at **2-5 years**. These screening tests are not covered by all insurance companies.

Below is a screening waiver form for each test. If you decline this recommended test, we have provided the CPT and ICD-9-CM code for you to check with your insurance company to see if it is a covered benefit.

PATIENT NAME: _____

VISION SCREEN WAIVER CPT-99173 ICD-9-CM-V72.0

ACCEPT

I would like my child to have a vision screening. I understand that if the cost (\$15) is not covered by my insurance that I will be responsible for payment of this test.

Signature _____ Date _____

DECLINE

I understand that Dr. Moore/Andy have recommended a vision screening for my child. I have chosen not to have the vision screen at this time.

Signature _____ Date _____

HEARING SCREEN WAIVER CPT-92587 ICD-9-CM-V72.1

ACCEPT

I would like my child to have an OAE screening. I understand that if the cost (\$75) is not covered by my insurance that I will be responsible for payment of this test.

Signature _____ Date _____

DECLINE

I understand that Dr. Moore/Andy have recommended an OAE screening for my child. I have chosen not to have the hearing screen at this time.

Signature _____ Date _____