



**ABC Health Care - Main Street Hospital
Healthcare Clinic**

Patient Name: _____ New Estab
please print

Date: _____ MR#: _____ Doctor: _____

Type of Insurance: _____ attach copy of card

Sent to financial counselor financial counselor signature: _____

| New Patient Visit | | | | |
|----------------------------------|--------------------------|---|------------|-----------|
| CPT Code | History/Physical | Medical decision making | approx min | fee |
| <input type="checkbox"/> 99201 | Problem focused visit | Straight forward decision making | 10 min | \$ 75.00 |
| <input type="checkbox"/> 99202 | Expanded visit | Straight forward expanded decision making | 20 min | \$ 108.00 |
| <input type="checkbox"/> 99203 | Detailed visit | Low complexity decision making | 30 min | \$ 144.00 |
| <input type="checkbox"/> 99204 | Moderate visit | Moderate complexity decision making | 40 min | \$ 204.00 |
| <input type="checkbox"/> 99205 | Comprehensive visit | Comprehensive decision making | >60 min | \$ 224.00 |
| Established Patient Visit | | | | |
| <input type="checkbox"/> 99211 | F/U minimal visit MD/RN | Minimal decision making | 05 min | \$ 40.00 |
| <input type="checkbox"/> 99212 | Focused follow up visit | Straight forward expanded decision making | 15 min | \$ 78.00 |
| <input type="checkbox"/> 99213 | Expanded follow up visit | Low complexity decision making | 25 min | \$ 102.00 |
| <input type="checkbox"/> 99214 | Detailed follow up visit | Moderate complexity decision making | 35 min | \$ 138.00 |
| <input type="checkbox"/> 99215 | Comprehensive follow up | Comprehensive decision making | >60 min | \$ 198.00 |
| <input type="checkbox"/> 99214 | Pre Op Clearance | | | \$ 78.00 |

| Procedures | Common Diagnoses | Other Diagnoses |
|---|--|--|
| <input type="checkbox"/> Accucheck \$5 | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Biopsy (explain below) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Polymyalgia |
| <input type="checkbox"/> BP Check \$0 | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Debridment (explain) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Ear Irrigation | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Flu Shot | <input type="checkbox"/> Burn (?degree) _____ | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Pneumovax | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Hemmocult | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> SLE |
| <input type="checkbox"/> Incision/Drainage | <input type="checkbox"/> Cancer (? Where) _____ | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Injection (explain) | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> TB |
| <input type="checkbox"/> Therapeutic Injection \$30 | <input type="checkbox"/> Cellulitis | <input type="checkbox"/> TB Exposure |
| <input type="checkbox"/> Pap Smear preparation \$40 | <input type="checkbox"/> CHF | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> PPD \$20 | <input type="checkbox"/> CMV Retinitis | <input type="checkbox"/> Ulcer ? |
| <input type="checkbox"/> Suture/Staple Removal n/c | <input type="checkbox"/> Constipation | <input type="checkbox"/> URI _____ |
| <input type="checkbox"/> Urine Preg \$10 | <input type="checkbox"/> Cough | <input type="checkbox"/> UTI _____ |
| <input type="checkbox"/> Therapeutic Injection \$30 | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Vaginitis |
| <input type="checkbox"/> Other procedures | <input type="checkbox"/> IDDM | <input type="checkbox"/> Pre-op Clearance |
| | <input type="checkbox"/> NIDDM | |
| | <input type="checkbox"/> DJD | |
| | <input type="checkbox"/> Eczema | |
| | <input type="checkbox"/> Osteoporosis (?Where) _____ | |
| | <input type="checkbox"/> Pharyngitis _____ | |
| | OTHER DX: _____ | |

Refer To: Allergy Derm ENT Eye Fertility GU Psych
 OB/Gyn Nurse Peds Podiatry Rheum Surgery Dietician

Other referral-please contact attending _____

Return Visit: _____
 Single Appt Double Appt

Attending Signature _____

Resident w/o attending Yes No Date _____

Previous Balance _____

Today's Charges _____

Discount _____ % _____

Amount paid _____

Balance Due _____