



**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	Medical History	Other Diagnoses
<input type="checkbox"/> Accucheck \$5	<input type="checkbox"/> Anemia	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Biopsy (explain below) \$15	<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) \$10	<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	_____