

**DISTRICT 2 PUBLIC HEALTH
CLINIC FEES POLICIES AND PROCEDURES
Policy # 169
Effective March 1, 2007
Revision Effective July 18, 2018**

I. COMMONLY USED TERMS IN THE FEE COLLECTION PROCESS:

The following definitions are set forth to insure there is no misunderstanding of commonly used terms or concepts and to provide definitions of key components of the fee system.

NOTE: Refer to specific programmatic guidelines to determine income utilized for fee collection.

A. CLIENT: Any person who is receiving or requesting services provided by the County Boards of Health and Contract Agencies.

B. DEPARTMENT: District 2 Public Health.

C. DECLARATION METHOD: Acceptance of proof of income regarding the source and amount of his/her family's gross monthly or annual income or income verification, i.e. current check stubs, W-2 form, income tax return, or Statement of Earnings from employer.

D. ABILITY TO PAY: Determined by assessment of current Federal Poverty Income Guidelines using annual gross income and family size.

E. FAMILY: (a) One or more adults and children, if any, related by blood or law, and residing in the same household. Where adults, other than spouses, reside together, each may be considered a separate family.

Minors seeking Family Planning services without parental consent shall be considered one-person families. **(b)** Emancipated Minor: adolescent is self-supporting, income would be handled the same as for an adult.

F. Household: Income of all persons combined that lives in the household. This income is utilized in the WIC Program. Refer to WIC Program Guidelines for specifics. This income is NOT utilized to determine any other program income in the Health Department.

G. ANNUAL GROSS INCOME: The sum of income, available to an individual or family on an annual basis, prior to any deductions or discounts. Sources of gross annual income follow:

1) WAGES OR SALARY: Total monetary earnings received for work performed as an employee, including wages, salaries, Armed Forces pay, commissions, tips, piece-rate payments and cash bonuses, earned before deductions are made for taxes, bonds, pensions, union dues, and similar purposes.

2) CHILD SUPPORT: An allowance contributed by a parent to assist in meeting the child's needs. **This income is NOT utilized to determine income in any of the Health Department Programs.**

3) ALIMONY: An allowance made to a spouse for maintenance and support, pending or subsequent to, legal separation or divorce.

4) UNEMPLOYMENT COMPENSATION: Compensation received from Government Unemployment Insurance Agencies or private companies during periods of unemployment and any strike benefits received from union funds.

5) WORKER'S COMPENSATION: Compensation received periodically from private or public insurance companies for injuries incurred at work. The cost of this insurance must have been paid by the employer and not by the person.

6) VETERAN'S PENSION: Money paid periodically by the Veteran's Administration to disabled members of the Armed Forces or to survivors for education and on-the-job training, as well as so-called "Refunds" paid to ex-servicemen as GI insurance premiums.

7) SOCIAL SECURITY: Social Security pensions and survivor's benefits, permanent disability insurance payments made by the Social Security Administration prior to deductions for medical insurance, and Railroad Retirement Insurance checks from the U.S. Government.

8) PENSIONS (PRIVATE/GOVERNMENT) OR ANNUITIES: Pensions or retirement benefits paid to a retired person or his/her survivors by a former employer or by a union, either directly or through an insurance company, and periodic receipts from annuities or insurance.

9) DIVIDENDS, INTEREST (ON SAVINGS OR BONDS), INCOME FROM ESTATES OR TRUSTS, NET RENTAL INCOME OR ROYALTIES: Dividends from stockholding or membership in associations, interest on savings or bonds, periodic receipts from estates or trust funds, net income from rental of a house, store, or other property to others, receipts from boarders or lodgers, and net royalties.

10) NET INCOME FROM NON-FARM SELF-EMPLOYMENT: Gross receipts minus expenses from one's own business, professional enterprise, or partnership. Gross receipts include the value of all goods sold and services rendered. Expenses include cost of goods sold and services rendered. Expenses include cost of goods purchased, rent, utilities, depreciation charges, wages and salaries paid, business taxes (not personal income taxes), and similar costs. The value of saleable merchandise consumed by the proprietors of retail stores is not included as part of net worth. Deficit or negative income from non-farm self-employment should be considered as a negative number when computing all applicable sources of income.

11) NET INCOME FROM FARM SELF-EMPLOYMENT: Gross receipts minus operating expenses from the operation of a farm by a person on his own account, as an owner, renter, or sharecropper. Gross receipts include the value of all products sold, government crop loans, money received from the rental of farm equipment to others, and incidental receipts from the sale of wood, sand, gravel, and similar items. Operating expenses include cost of feed, fertilizer, seed, and other farming supplies, cash paid to farmhands, depreciation charges, cash rent, farm taxes (not state and federal income taxes), and similar expenses. The value of fuel, food, or other farm products used for family living is not included as part of net income. Deficit or negative income from farm self-employment should be considered as a negative number when computing all applicable sources of income.

12) PUBLIC ASSISTANCE OR WELFARE PAYMENTS: Public assistance payments such as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Optional State Supplementation (OSS), and general assistance (e.g., county assistance).

II. GENERAL

A. OBJECTIVES

To have a customer-sensitive, staff-supported, fee collection system that will increase revenues, comply with Federal and State guidelines, and enhance the clinic programs. Policies and procedures governing fee payments must be administered in a manner which

protects the privacy of the individual. They should also insure that the client understands his/her rights within the system.

B. ESTABLISHMENT OF THE DISTRICT 2 PUBLIC HEALTH FEES POLICIES AND PROCEDURES MANUAL

Every HD shall maintain the most current copy of the District 2 PH Fee P & P Manual. The COM will be responsible for updating staff regarding changes.

C. AUTHORITY AND RESPONSIBILITY

1. Routine decisions in accordance with this policy will be made by the COM and CNM. This includes the local management team's ability to waive or discount fees as deemed appropriate.
2. The execution of these policies in the County Health Department will be a cooperative effort between the County Office Manager (COM) and County Nurse Manager (CNM). They are authorized to make minor, temporary deviations from these policies in extraordinary circumstances with proper documentation.
3. No changes are to be made to these policies unless the directive for the change has been made in writing by the District Health Director.
4. The IT Team is responsible for updating changes to the M & M Computer System and will notify all counties via the "Local Billing Committee".

III. FEE SCHEDULES

A. District 2 Public Health utilizes guidelines and policies set forth by the Federal and State Programs and insurance companies to set fees. Programmatic fees are not regulated by the County Boards of Health, rather by the Programs. County purchased vaccine and other supplies are regulated by the county, i.e. flu and other county purchased vaccine, condoms, pregnancy tests, etc. Quest Labs is a local program. Fees are set according to what the Health Departments pay Quest Labs plus a draw fee. These labs are subject to change and waiver of fees is not permissible due to the cost to the local Health Department.

B. Note that the environmental health fee schedule lists the only approved amounts to be charged for services provided. These fees must be approved by both the County Board of Health and the county governing authority (i.e. the County Commissioners). These amounts may not be changed by anyone without prior approval of both the Board of Health and the county governing authority.

IV. FEE COLLECTIONS

A. PAYMENT AT TIME OF SERVICE

Payment is expected at the time of service for all services provided. Method of payment may include cash, personal check (except as described below), credit card and debit card. **Under NO CIRCUMSTANCE should a Health Department accept a postdated check or hold a check past the date of service.** All effort is to be made to collect fees owed at the time of the client's visit. Each Health Department will determine if payment is made prior to or after services are rendered. However, the following is recommended:

1. Efforts should be made to collect any outstanding balances when clients return for a new service. If the client states they cannot pay the outstanding

balance, an effort should be made to initiate a payment plan based upon programmatic guidelines.

2. Payment may be collected after services are rendered (i.e. at the end of the visit) for appointments, childhood immunizations, and infectious disease services when a return visit is expected.
3. Personal checks should not be accepted for one-time services, such as travel clinic visits or immunizations (adult).
4. Payment for debts, i.e. a returned check and/or any outstanding balance within the current or last fiscal year, is to be collected at the same time the payment for any new service is collected, as specified in #1 (i.e. up front for walk-in services).
5. NOTE: Any outstanding balance should be noted in VHN under the "ALERTS" section in VHN, along with a Detailed Financial note in the patient billing screen.
6. Insurance cards must be presented at time of service, to have the patient's insurance billed for that date of service.

B. ASSIGNMENT OF BENEFITS

Each HD accepts assignment of benefits from Medicaid, Medicare, and certain private commercial insurance companies. For insurance companies that we are not allowed to bill, a receipt is given to each patient that contains the appropriate information in order for clients to bill their insurance companies.

C. PROCEDURES FOR PARTIAL OR NON-PAYMENT

If a client or guardian fails to pay their bill, the County Office Manager (COM) or designee should discuss the situation with the responsible party to determine the reason for non-payment. Clients and guardians should always be encouraged to discuss bills and fees openly. If full payment cannot be made by a specific date, an installment plan should be established according to programmatic guidelines and documented in the client's medical record. A copy of the proof of income, if provided, should be scanned into the medical record for documentation. Only 1 copy per year is required with no job change in that year. **Note: Be sure to follow programmatic guidelines in establishing a payment plan. Some programs do not allow billing: i.e. VFC Vaccines.**

1. If a client makes a partial payment or no payment, but makes arrangements for payment prior to leaving the facility, a Statement of Account or receipt stating the amount due and asking the client to return payment within 30 days or prior to their next visit, shall be given to them at the time they check out.
2. If a client leaves the facility without making any payment and without making arrangements for payment, a Statement of Account is to be sent to that client, stating the amount due, payable within 30 days or prior to their next visit. Statements should be sent at least monthly for all new service visits and Quarterly for any outstanding services visits. **Note: A no contact client SHOULD NOT be sent a statement.**

See Section VIII for additional billing and collection procedures.

V. GUIDELINES FOR INCOME ASSESSMENT

To comply with programmatic state and federal regulations, each client must have their income assessed and documented in the record annually. This should be accomplished per

HIPAA compliant guidelines. Most programs follow specific regulations for income verification and fee collections. See specific program manual for regulations

Many clinic services are provided on a sliding fee scale. To determine the client's percent pay level and discount, income and family size are required or requested per program guidelines. The District 2 Confidential Discount Eligibility Form should be used to determine eligibility for discounts. (Note that Environmental Health fees are not discounted.)

DOCUMENTS THAT CAN BE UTILIZED TO PERFORM THE FINANCIAL ASSESSMENT:

- Monetary compensation for services, including wages, salary, commission, or fees
- Net income from farm and non-farm employment
- Dividends or interest on savings or bonds, income from estates or trusts, or net rental income
- Public assistance or welfare payments
- Unemployment compensation
- Government civilian employees' or military retirement, pension, or veterans' payment
- Private pension or annuity payments
- Alimony payments
- Regular contributions from person(s) not living in the household
- Basic Allowance for Subsistence (BAS) is cash payment added to base pay and is counted as part of all cash income for military families ONLY
- Net royalties
- Other cash income including, but not limited to, cash amounts received or withdrawn from any source that would be taxable including investment and trust accounts

EXCLUDED SOURCES OF INCOME:

- Bank Loans
- Student Loans
- Child Support
- Food Stamps
- Social Security Benefit and /or Supplemental Security Income
- Any other non-taxable receipts

Immunization Services:

There are federal rules and regulations regarding waiving fees for VFC vaccine. VFC eligibility takes place with each immunization to ensure that eligibility status has not changed. If the parent states an ability to pay the VFC administration fee, proceed with usual fee process. If the parent states an inability to pay the VFC administration fee, waive this fee utilizing code # 848. Is it necessary to verify a parent's ability to pay? Per VFC, the Health Department will not verify by checking income – Meaning, we take the person's word for it. If the parent/client states they can bring the money back when they get paid, then take the money when they return and add it to the appropriate account. But in no way, should the amount be on the account as "owing" for the vaccine. Reference: State of Georgia Immunization Program

VI. DENIAL OF SERVICE

No client shall be denied any service or have services rescheduled because of a true inability, as opposed to unwillingness, to pay, regardless of their credit standing. A statement must be posted in the Lobby of the Health Department, which states that no one will be denied services because of inability to pay. County Health Departments are required to serve all those who request services without regard to length of county residency, number of times a service has been provided, prior approval by a physician, a true inability to pay, or other limitation unrelated to the need for a specific service.

Note: Federal guidelines must be followed for federal programs.

VII. POLICIES AND PROCEDURES FOR HANDLING MONIES AND DEPOSITS

A. CASHING CHECKS AND MAKING CHANGE

Personal checks, traveler's checks and credit/debit cards will be accepted for the payment amount only. (See IV.A.2. for instances in which a personal check should not be accepted). No one is permitted to give cash back from checks or credit cards. No cashing of checks of any kind is permitted. If a personal check is accepted, make sure to record the Driver's License number on the front of the check. In the event the check is returned for insufficient funds, magistrate court can track the person through the driver's license number.

B. DAILY MONEY REPORT AND BALANCING

Fees collected must be reconciled and balanced daily. The total cash, checks and credit card slips must be reconciled. Money kept in the cash drawer should be counted after making each deposit to ensure that there are no overages or shortages. The person who prepares the Daily Money Report should sign off as preparer and then the report should be reviewed for accuracy and completeness and signed off by the supervisor. Rationale: DHR Office of Audits, 2009. Adjustment passwords should be assigned to 2 managers only.

C. SECURITY

All fees collected must be secured in a locked drawer. Deposits must be taken to the bank at least twice a week. Additionally, on any day when the total amount of cash in the Health Department equals or exceeds \$500.00, a deposit is to be made by the close of business if possible, but no later than 2:00 p.m. of the next working day. As an additional security measure, a single person should not accept payments, reconcile the money drawer and prepare the deposit, and take the deposit to the bank. At least two staff members should be involved in this process.

D. CLIENT FEE REFUNDS

Process for client fee refunds:

- Refund requests must be processed on the **FEES REFUND REQUEST FORM (3/2011)**. This form must be placed on county health department letterhead.
- The patient's name and address must be listed.
- The reason for the return must be given.
- The amount and what the original payment was for must be given.
- A transaction list for the client from VHN must be attached.
- The employee requesting the refund must sign the request along with supervisor or another witness.
- Absolutely **NO CASH** refunds are to be given.
- Send the Request Form and transaction list to the District Accounts Payable Department or your local county office manager for processing. A check will be sent to the individual within 7 – 10 working days.
- When the client uses a credit/debit card, an immediate refund can be issued by reversing the charges through the credit card system. Please note this on your fee re-cap report.

VIII. BILLING AND COLLECTION PROCEDURES

A. INSURANCE BILLING

Billing is one of the most important components of a Health Department's responsibility to maintain fiscal viability. It is recommended that all third-party payment billing be performed weekly, no less than monthly, or on a schedule which guarantees timely payment and assures re-billing payments.

B. STATEMENT PROCEDURES

Statements of outstanding balances should be mailed monthly, if possible, but at least once a quarter. Balances of \$5.00 or less are not required to have a statement mailed.

Do not send statements for a "No Contact" patient.

C. AGING OUTSTANDING ACCOUNTS RECEIVABLE

1. Bad debts must be written-off by June 30th of each year. Balances must be kept for the current and last fiscal year. Any balances incurred prior to the previous fiscal year may be written off if the client has not received any services in the current or last fiscal year. Notes regarding all debts written off must be entered into the "Alert" section of the client's computer record and in the financial notes. Set the priority as "1" and leave the program ending date fields blank. Enter the amount of bad debt written off in the comment section.
2. If the client returns to the clinic and makes a payment toward the debt that has been written off, payment will be accepted. The adjustment code 781 (recover write-off) is to be used, and the original amount written off. This will add the balance back. The payment received is then to be posted as usual. Remove the "Alert" from the patient's record.

IX. RETURNED CHECKS POLICY

Every effort should be made (by telephone, in-person, or by mail) to contact the individual who wrote an NSF check to determine when funds will be available for the Health Department. See the attachment for an example of a letter to be sent regarding NSF checks. The individual should commit themselves to a specific date (within ten days, per GA law). A \$30 penalty will be charged for returned checks by the Health Department. A notice should be placed in the lobby stating all returned checks are subject to a \$30.00 fee. The code for an NSF check is AHLU 125. This code will add the \$30.00 charge into their billing record. You will need to add the amount of the NSF check to this amount. If the NSF check is for CH, then the code should be CHLU125.

Note: refer to www.ncourt.com , choose your county, choose frequently asked questions on the bottom left hand side, then choose Bad Check FAQ. Some counties in our District are not represented. Please call your local magistrate court for instructions.

Each county's Magistrate Court policies on bad checks may vary. Visit your local Magistrate Court to determine what process your Health Department should follow. The Civil Procedure/letter only is included in this fee manual.

X. PATIENT RECORD CHARGES

The Official Code of Georgia Unannotated, Code 31-33-3 allows a charge for search, retrieval, and other direct administrative costs related to copying and mailing patient records.

Official Code of GA 31.33.3

(a) The party requesting the patient's records shall be responsible to the provider for the costs of copying and mailing the patient's record. A charge of up to \$25.88 may be collected for search, retrieval, and other direct administrative costs related to compliance with the request under this chapter. A fee for certifying the medical records may also be charged not to exceed \$9.70 for each record certified. The actual cost of postage incurred in mailing the requested records may also be charged. In addition, copying costs for a record which is in paper form shall not exceed \$.97 per page for the first 20 pages of the patient's records which are copied; \$.83 per page for pages 21 through 100; and \$.66 for each page copied more than 100 pages. All the fees allowed by this Code section may be adjusted annually in accordance with the medical component of the consumer price index. The Office of Planning and Budget shall be responsible for calculating this annual adjustment, which will become effective on July 1 of each year. To the extent the request for medical records includes portions of records which are not in paper form, including but not limited to radiology films, models, or fetal monitoring strips, the provider shall be entitled to recover the full reasonable cost of such reproduction. Payment of such costs may be required by the provider prior to the records being furnished. This subsection shall not apply to records requested in order to make or complete an application for a disability benefits program. (b) The rights granted to a patient or other person under this chapter are in addition to any other rights such patient or person may have relating to access to a patient's records; however, nothing in this chapter shall be construed as granting to a patient or person any right of ownership in the records, as such records are owned by and are the property of the provider.

This is the original Code of Georgia as written. It is updated by the Office of Planning and Budget annually.

XI. MEDICAID BILLING

General guidelines regarding Medicaid:

All Health Departments are Medicaid providers and all policies and procedures set forth by Medicaid must be followed. Medicaid manuals are available on the GHP web portal at www.mmis.georgia.gov and are updated frequently. Please visit these websites to download / print the most current versions.

- Payment for a Medicaid billable service cannot be required.
- Medicaid/CMO eligibility must be verified at time of service.
- Eligibility must be documented in VHN for every visit.
- Patients cannot be balance billed for a Medicaid billable service.

DONATION GUIDELINES

Voluntary donations from clients are permissible

Display notice regarding acceptance of donations is permitted.

Donations may be accepted from clients who fall in the no fee category (zero pay).

Donations must **NEVER** be a prerequisite to the provision of services or supplies.

Clients must **NEVER** be pressured or coerced to make donations.

Donation amounts should not be suggested.

Donations from clients do not replace or serve to waive the billing/charging requirements or the client's responsibility for payment of fees.

All donations must be documented as such in the client's financial record.

Clinic staff should provide a receipt to the client with "donation" and the amount donated noted on the receipt.

Clinic staff should turn in donation and copy of receipt to Administrative/ Financial staff.
Financial information shall be reviewed as part of the District Q&A activities.

Sample: BAD CHECK LETTER – CIVIL ISSUE
Ten-day Double Damages Letter Pursuant to O.C.G.A. 13-6-15

PLACE ON COUNTY LETTERHEAD

To: Patient Name
Address
City, State, Zip Code

You are hereby notified that a check or instrument numbered _____ by you on _____ (Date), drawn upon _____ (Name of Bank) and payable to _____ has been dishonored. Pursuant to Georgia Law, you have TEN (10) Days from the receipt of this notice to tender payment of the FULL amount of the check or instrument plus a service charge of \$30.00 or 5% of the face amount of the check or instrument, whichever is greater, the total amount due being, \$_____. Unless this amount is paid in FULL within the TEN (10) day period, the holder of the check or instrument may file a civil suit against you for TWO times the amount of the check or instrument, but in; no case more than \$500.00 (Five Hundred Dollars), in addition to the amount of the check or instrument, plus any court costs incurred by the payee in taking the action.

SEND PAYMENT TO:

_____ County Health Department
Address
City, State, Zip Code
Attention: _____

Memo: Certified Mail No. _____ Date Mailed _____
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Handling NSF Checks

Every effort should be made (by telephone, in-person, or by mail), to contact the individual who wrote the NSF check to determine when the funds will be available for the Health Department.

The individual should commit themselves to a specific date (within ten days, per Ga law). Cash should only be accepted for the returned check amount and a \$30.00 penalty fee will be charged.

In VHN you will pull up the patient and go to the billing screen. Click ADD.

Enter AHLU125 for any Adult Health service fee where the NSF was from, or CHLU125 for a Child Health service fee where the NSF was from.

The Serv code, CPT code, Diag Code, Program, Paytype, Servdate and Center # will automatically populate. The charge will default as \$30.00. You will need to overwrite this charge, adding in the amount of the NSF to the penalty fee. Then you will post the payment using the payment code of 201 (cash). Enter amount paid. Print a Receipt!

This will print out on your money report for that day.

At the bottom of your breakout slip, list the amount of the returned check and penalty fee. Attach the notice from the bank, to the deposit slip that is sent to Kay.

Copy and Pasted the below, to your letterhead

Date: Click or tap here to enter text.

Patient/Guardian/Client: Click or tap here to enter text.

Address: Click or tap here to enter text.

City, State Zip: Click or tap here to enter text.

Dear: Click or tap here to enter text.

According to our records, you owe \$ Click or tap here to enter text.. you are being asked to make a reasonable effort to pay the amount you owe.

We appreciate you making full payment of the amount you owe. If this is not possible, we will accept installment payments. If you would like to make installment payments, please complete the section below and sign your name acknowledging your understanding of the terms and conditions of this agreement.

I have chosen to pay the amount I owe as follows:

Amount: _____

Weekly

Bi-weekly

Monthly

I understand the terms and conditions of this agreement.

Date: _____

Signature: _____

Cc: patient's file

**County Health Department Fees
Effective 10/1/2013 (For Reference)**

Immunizations:	Fee
Vaccines for Children	\$21.93
Therapeutic Injection	\$10.00
Back loading Only: Do Not charge IF immunization services are provided that day	\$10.00
County Purchased Vaccines: Price varies depending on vaccine and manufacturer	
Flu Shot Regular Dose	\$25.00
Flu Shot High Dose (Medicare approved rate)	\$66.00
Certificates:	
Day Care, School or College	\$5.00
H/V/D, Reactor Card, TST, or Proof of Pregnancy (charge when certificates are given as duplicate or without a service)	\$5.00
Fax	\$3.00
Lab Tests: Refer to Office Visit CPT Code List below	
Pregnancy Test - walk in GL self-pay (Pregnancy test screen will create 99211 \$20 and PTST \$8 for the total)	\$28.00
Urine Screen - (AH OV 99211 or service code as determined by RN + "UA" Test \$4)	\$24.00-\$84.00
Venipuncture/Lab Draw for 1 to 3 Tests "LDRAW"	\$25.00
Venipuncture/Lab Draw for 4+ Tests "LDRAW4" <i>Do not use LDRAW4 for HIV screen (see below for HIV screen)</i>	\$35.00
Finger stick (Glucose and HGB)	\$10.00
Lead finger stick State Lab (LEAD-ST)	\$10.00
Lead finger stick Medtox Lab (LEAD)	\$15.00
INSTI HIV Screen (STD service encounter choose OV 99212 \$35 for "New" and "Est" HIV screen)	\$35.00
TST Skin Test	\$20.00
Chest X-ray (XRAY)	\$75.00
Other Labs vary per Quest individual charges and/or GPHL (refer to GHPL vs Quest comparison <i>Cheat Sheet</i>)	
Exams/Screenings GC:	
Head Lice Check (AH or CH service encounter, choose OV 99211 \$20, and choose LU110 in procedure)	\$20.00
Hearing/Vision/Dental/Nutrition Screen	\$25.00
Hearing Screen	\$7.00
Vision Screen	\$7.00
Dental/Nutrition Screenings (Dent/Nut)	\$11.00
Child Health Nutrition Screenings (CHNut)	\$11.00
Rash Evaluation (AH or CH OV 99211 \$20)	\$20.00
Other:	
Car Seat Safety Counseling	\$10.00
Nonsufficient Funds Fee (returned check) (AH Procedure Code LU125) or 5% of check	\$30.00
Condoms - County Purchased (40 per unit) (AH Procedure Code LU105)	\$10.00
Child Health:	
Dental-Emergency Assessment (Non-Medicaid)	\$25.00
Child Health Physical (Non-Medicaid)	\$28.00-\$70.00
Family Planning:	
Office Visit based on level of service determined by Provider + labs + tests (refer to FP service ticket for further cost breakdown)	
STD:	
Office Visit based on level of service determined by Provider + labs + tests (refer to STD <i>Cheat Sheet</i>)	
BCCP:	
Office Visit based on level of service determined by Provider + labs + tests (refer to BCCP Program <i>Cheat Sheet</i>)	
AH Women's Wellness Visit (Non FP/BCCP)	
Office Visit based on level of service determined by Provider + labs + tests (refer to AH <i>Cheat Sheet</i>)	
TB:	
Office Visit based on level of service determined by Provider + labs + tests (refer to TB <i>Cheat Sheet</i>)	\$20 or \$40
T-SPOT Self Pay (\$55.00 test + \$25.00 Lab Draw)	\$80.00
T-SPOTINS Private Insurance (Send copy of Insurance card to pay for \$55.00 test and collect \$25.00 cash Lab Draw fee)	\$25.00
Office Visits: Provider refer to E/M Coding Tool AH/STD/Walk In Services	
99211 Established Minimal Problem Focused	\$20.00
99201 New Problem Focused	\$40.00
99212 Established Problem Focused	\$35.00
99202 New Expanded Problem focused	\$60.00
99213 Established Expanded Problem Focused	\$45.00
99203 New Detailed Low Complexity	\$80.00
99214 Established Detailed Moderate Complexity	\$65.00
99204 New Comprehensive Moderate Complexity	\$115.00

NOTES: When H/V/D and Immunizations services are provided, the certificate is included in the charge