CANYON Pediatrics

Self Pay Fee Schedule

Horario de pago por cuenta propia

CPT Code	Description	Price	CPT Code	Description	Price	CPT Code	Description	Price	CPT Code	Description	Price
New Patient Sick Visit			Immunizations			Procedures			Other		
99202	Level 2	$ 125.00	90460	Admin	$ 20.00	30300	FB Removal, Nasal	$ 200.00	95115	Allergy Inj, 1st	$ 20.00
99203	Level 3	$ 145.00	90686	Influenza	$ 30.00	54150	Circumcision	$ 300.00	95117	Allergy Inj, Addt'l	$ 20.00
99204	Level 4	$ 195.00				69210	Cerumen Removal	$ 45.00	99900	Sports Exam	$ 30.00
99205	Level 5	$ 245.00				A4550	Surgical Tray	$ 15.00			
Established Patient Sick						17110	Wart Removal	$ 110.00			
99212	Level 2	$ 80.00				94640	SVN Treatment	$ 25.00	Behavioral Health		
99213	Level 3	$ 100.00				A7015	SVN Mask & Tube	$ 10.00	90791	Assessment	200
99214	Level 4	$ 150.00	Injections						90837	60 Min Tx	100
99215	Level 5	$ 245.00	96372	Injection	$ 20.00						
New Patient Well Exam			J0696	Rocephin 250mg	$ 40.00	Surgeries					
99381	Level 1	$ 150.00	J2920	Solumedrol 40mg	$ 8.00	10060	I & D Abcscess, Simple	$ 120.00			
99382	Level 2	$ 150.00	J2930	Solumedrol 125mg	$ 10.00	10061	I & D Abcscess, Comp/Multi	$ 165.00			
99383	Level 3	$ 150.00	J8540	Decadron Per mg	$ 4.00	10160	I & R foreign Body, SubQ	$ 125.00			
99384	Level 4	$ 150.00	Laboratory			11200	Removal Skin Tags 1-15	$ 100.00			
99385	Level 5	$ 150.00	81002	UA	$ 10.00	11730	Nail Removal	$ 100.00			
Est Patient Well Exam			81025	Pregnancy Test	$ 15.00	11732	Nail Removal, Each Addt'l	$ 50.00			
99391	Level 1	$ 130.00	82270	Hemocult	$ 15.00						
99392	Level 2	$ 130.00	82962	Gluscose, Finger	$ 10.00						
99393	Level 3	$ 130.00	86580	TB Skin	$ 20.00						
99394	Level 4	$ 130.00	87880	Rapid Strep	$ 25.00						
99395	Level 5	$ 130.00	89804	Flu	$ 25.00						

By Signing this Agreement, I acknowledge that I understand that due to the individual needs of each patient the fees listed above are only estimates. Payemnt in full is to be made prior to services being rendered. In the event my care exceeds the amount of the estimate, I understand that I a financially responsible for paying the entire balance due at the time of serice.

Al firmar este Acuerdo, reconozco que entiendo que, debido a las necesidades individuales de cada paciente, las tarifas mencionadas anteriormente son solo estimaciones. El pago completo se realizará antes de que se presten los servicios. En el caso de que mi atención supere la cantidad estimada, entiendo que soy responsable financieramente de pagar el saldo total adeudado en el momento del servicio.

Signature _____ Date _____

CANYON Pediatrics

Sliding Fee Scale

Escala de tarifa móvil

Last SFS Application Date _____

SFS Level _____

Household Income _____ Number in Household _____

Level	0	1	2	3	4	Canyon Fee Schedule	SFS Payment
Service	>100%	100-150%	150-200%	200-250%	250-300%		
Visits	$ 10.00	$ 25.00	$ 50.00	$ 75.00	Lesser of $100 or Fee Schedule		
Co-Pays	$ 10.00	25%	50%	75%	100%		
Labs in-house	$ 10.00	25%	50%	75%	100%		
					Total		

Disount _____

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_____ _____

Signature Date