

**NEW HANOVER COUNTY  
HEALTH DEPARTMENT**

**FEE POLICY**

**Revised**

**July 20, 2009**

**NEW HANOVER COUNTY HEALTH DEPARTMENT  
FEE POLICY**

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**SECTION I**

**ANIMAL CONTROL SERVICES**

**ANIMAL CONTROL SERVICES FEES**

**Cats/Dogs**  
**Unaltered**

**Spayed/Neutered**

Cats/dogs under 1 year of age	1 year license	\$10.00	\$ 10.00
Cats/dogs 1 year of age or older	1 year license	\$10.00	\$ 20.00
Cats/dogs 1 year of age or older	3 year license	\$25.00	\$ 50.00

Any owner of a handicap helper dog, which is used for seeing or hearing purposes and can show proof of spay/neuter, shall receive a license free of charge.

**SPECIALTY PET LICENSES**

**# of Cats/Dogs**

**License Fee**

05 – 10

\$ 45.00

11 – 20

\$ 70.00

21 – Over

\$100.00

**Types of Specialty Pet Licenses (Fees above apply to each type):**

**1. MULTIPLE PET LICENSE**

Any combination of dogs and cats

All must be neutered or spayed.

Good for one year (renewable on date of purchase)

**2. SHOW BREEDER LICENSE**

Either dogs or cats (may not be combined).

Do not have to be neutered or spayed.

Good for one year (renewable on date of purchase).

Kennel must participate in three AKC or UKC sanctioned events per year (proof to be shown) or equivalent for cats, or six in three years.

**3. HUNTING DOG LICENSE**

Dogs only

Do not have to be spayed or neutered

Good for one year (renewable on date of purchase)

Kennel must participate in three lawful or sanctioned events per year (proof when possible).

Proof of N.C. hunting license

**No refund due to death or loss of ownership.**

**SHELTER**

\$10.00 per day  
\$15.00 per day bite animals/dangerous dogs

**ADOPTION**

Cats/Dogs	\$60.00
Other - Large	\$25.00
- Small	\$ 3.00

**REDEMPTION**

All Animals	Owner's Offense	
	1st	\$ 20.00
	2nd	\$ 60.00
	3rd	\$100.00
	4th	\$150.00
	5th or more	\$250.00

**MISCELLANEOUS FEES**

Euthanasia Fee	\$ 20.00
Breeder Permit	\$ 20.00
Collars/Leashes	\$ 5.00

**ADOPTION REFUND POLICY**

Refunds for adoptions may be granted if the following conditions are met:

1. The adopted animal is returned.
2. The adopted animal is examined by a veterinarian within five working days from the adoption date and a health problem is noted.
3. The adoptee produces either a handwritten note or a computer generated report from the veterinarian stating the findings and date examined.

The amount of refund will be the total of adoption fee and county license fee, if purchased and returned. **The adoptee is responsible for any charges by the veterinarian.**

## CIVIL CITATIONS\*

<u>Section/Description</u>		
5-1 (d)	Interference with any Duly Appointed Agent	\$150.00
5-4 (d), (g)	Restraint - Dogs Tied Out or Outside Enclosure	\$250.00
5-4	(2) Public Nuisance	
	First Violation	\$50.00
	Second Violation	\$100.00
	Three or More Violations	
	\$200.00	
5-5	(A) County License Fee	\$100.00
	(B) Rabies Vaccination	\$200.00
5-6	Keeping Stray Animals	\$25.00
5-7	Rabies Vaccination and Control	\$500.00
5-8	Wearing of Collar, Tags, & Identification	\$15.00
5-9, 5-4 (d)	Dogs/Cats Running-at-Large*, Leash Requirement*	
	First Violation	\$25.00
	Second Violation	\$75.00
	Third Violation	\$200.00
	Fourth Violation	\$300.00
	Five or More Violations	\$500.00
	Unprovoked Dog Bite/Running Loose	\$500.00
5-10	Vicious Animals	\$500.00
5-11	Barking Dogs	
	First Violation	\$50.00
	Second Violation	\$100.00
	Three or More Violations	\$250.00
5-12	Teasing and Molesting	\$100.00
5-13	Injuring Animals, Notice Required	\$100.00
5-14	Health and Welfare	\$300.00
5-15	Manner of Keeping & Treating Animals	\$300.00
5-16 (d)	Sterilization of Cats & Dogs	\$250.00
5-16 (i)	Animals imp./Judicial process/Admin. seizure	\$500.00
5-19	Interference with Trap or Cage	\$100.00
5-23	Collection of Cats and Dogs for Resale	\$500.00
5-25	Dogs prohibited at Mason Inlet*	
	First Violation	\$ 25.00
	Second Violation	\$ 50.00
	Three or More Violations	
	\$ 75.00	
5-26 above)	Dogs Running-at-Large at Mason Inlet* (Same violation fees for Section 5-9, see	
5-27	Proof of Sterilization/Animals Adopted in New Hanover County	\$500.00
5-28 to 29	Permit for Kennels	\$500.00
5-61 to 65	Dangerous Dogs/Potentially Dangerous Dog Violations	\$500.00
5-66	Responsible Breeding Permit	\$250.00

**Ferret Regulation**

Rabies Vaccination	\$200.00
County Pet License Fee	\$100.00
Unprovoked Bite	\$500.00
Provoked Bite	\$100.00

\*The owner of an animal shall be subject to escalating fees. The fees are directed toward and against the owner. The purpose of the fee is to affect the conduct of the owner by seeking to have an owner responsibly maintain a sufficient restraint and confinement of their animal.

## SECTION II

### ENVIRONMENTAL HEALTH DIVISION

The attached schedule of fees has been established for certain Environmental Health Division services. Payment is required prior to the provision of these services. Fees must be accompanied by the appropriate application and any other necessary documents or maps, and are payable ONLY in the Environmental Health Office OR through the US Postal Service. Staff SHALL NOT accept or agree to transport any payment of fees during their conduction of field work.

Fees are collected and recorded by the management support staff in the office during the hours of 7:30 AM until 5:00 PM. A receipt shall be issued for each fee collected. In the event that all management support staff are away from the office for a period during the specified hours, an Environmental Health Specialist shall be designated by Environmental Health management staff to accept applications, collect fees and issue receipts.

A daily deposit of collected fees shall be made between 3:00 PM and 3:30 PM with the appropriate Health Department management support staff person.

08/97

# ENVIRONMENTAL HEALTH FEE SCHEDULE

SERVICE	
Soil Evaluation	\$ 281.00 * plus \$100 each additional 500 gal/day
Sewage System Construction Authorization (Type I, II, III)	\$ 280.00
Sewage System Construction Authorization (Type IV, V, VI)	\$ 832.00 * plus \$100 each additional 500 gal/day
Sewage System Permit Revision	\$ 140.00
Sewage System Repair Permit	\$ 50.00
Existing System Inspection (Building addition or Private pool)	\$ 140.00
Existing System Inspection (Reuse Purposes)	\$ 140.00
Reissue or Revise Construction Authorization	\$ 140.00
Land Record Review	\$ 100.00 plus \$50 each additional hour
Installer Registration - Unrestricted	\$ 280.00 per year or prorate per quarter
Installer Registration - Restricted (homeowner)	\$ 28.00
Well Permit (including site evaluation & bacteriological analysis)	\$ 200.00
Water Sample - Bacteriological	\$ 140.00
Water Sample - Bacteriological - resample	\$ 70.00
Water Sample - Chemical	\$ 140.00
Well Driller Registration	\$ 280.00 per year or prorate per quarter
Rat Bait	\$ 4.00 per pound
Seafood Market Permit	\$ 100.00
Seafood Vehicle Permit	\$ 50.00
Swimming Pool - Operation permit	\$ 200.00 **
Swimming Pool - Plan Review (new facility construction)	\$ 250.00
Temporary Food Establishment Permit	\$ 50.00 each relocation
Temporary Food Facility Application	\$ 30.00 each day of operation
Temporary Food Facility Penalty	\$ 20.00 *** per day
Tattoo Artist and/or Body Piercing Permit per location	\$ 200.00
Temporary Tattoo Artist and/or Body Piercing Permit	\$ 100.00 **** operate 2 weeks or less
* First 500 gal/day	
** Second & subsequent facility @ same address 25% reduction	
*** Application submitted less than 14 calendar days prior to event	
**** Permit to operate 2 weeks or less	

**REFUNDS REQUESTED PRIOR TO PROVISION OF SERVICE WILL BE GRANTED ON THE BASIS OF \$10.00 FILING CHARGE WITH THE EXCEPTION OF RAT BAIT BEING NON-REFUNDABLE**

# NEW HANOVER COUNTY HEALTH DEPARTMENT

## FEE POLICIES

### I. General Guidelines

- A. The fee system implemented by this organization has been approved by the New Hanover County Board of Health (NHCBOH). Implementation date was July 1, 1984. For the Women's Preventive Health Section fee system was approved by the NHCBOH in October 1983.  
Revision Date: December 2005.
- B. Services provided for the protection of the public's health and prevention of disease will not be denied based on inability to pay. Every effort will be made to provide services to patients at or below 150% of poverty.
- C. Unless confidentiality is a barrier, if a patient has any form of third-party reimbursement, to include Medicaid, Medicare and other private insurance, that payer must be billed for services, with the exception of flat rate charges. Medicaid will be billed as the payer of last resort. Patients must sign the Authorization and Assignment of Benefits Form (Page 43 for all third party reimbursement).
- D. Patients who are receiving Medicaid (Title XIX) will submit their Medicaid number for third party payment. Reimbursable visits will be claimed to Title XIX for payment and no further charges will be made to the patient.
- E. Sliding fee scales will be applied in specified programs (Pages 34-36).
- F. The New Hanover County Health Department (NHCHD) will require "proof of income" to reduce charges when applying the sliding fee scale. If a patient is unable to produce this required information, they will be placed on a 100% sliding fee scale status, for a period of ten (10) business days. If proof of income is provided within the ten business-day period, the patient will be billed accordingly. If proof of income is not provided within the established timeframe, the patient will be billed at 100% for all patients with the exception of Family Planning patients in the Women's Preventive Health program. The NHCHD representative has the right to verify income information in all cases, however the patient must read, understand, and sign the income statement (Page 41) in order for their income to be checked. The sliding fee scale does not apply to all services. Services with flat rate fees do not require proof of income. In extreme or unusual circumstances, the Health Director or designee may make exceptions.

- G. If a patient prefers not to produce required proof of income information, they will be placed on a 100% sliding fee scale status. However, the patient must read, sign, and date the waiver on the NHCHD Income Statement (Page 41).
- H. Payment or co-pay for third party billing is expected at the time of service for all chargeable services. Applicable deductible and co-insurance amounts will be billed to the patient upon receipt of insurance Explanation of Payment. Partial payment is accepted for all chargeable services, with the exception of flat fee services. Co-pays are not subject to sliding fee scale. Medicaid patients are exempt from co-pays. Payment for non-covered services is expected at time of service. Patient must sign the Acknowledgment of Non-Covered Services form to accept responsibility for payment of designated services.
- I. If a patient has a remaining balance on their account, a payment agreement and schedule will be established and signed by the patient (Page 42). Patients who have demonstrated no “good faith” effort to pay may be subject to service restrictions with the exception of Family Planning services and those services provided to patients per State laws (see N. Page 11).
- J. Payment in full is required at the time of service for vaccines not supplied by the State, with the exception of flu, pneumonia, and meningococcal vaccines provided to Medicaid, Medicare Part B, and Health Choice recipients and vaccines provided to BCBS recipients. Insurance companies will not be billed for these vaccines except for Blue Cross Blue Shield (to include State Health Plan) due to our contractual agreement. Patients will be provided a receipt for submission to their insurance company.
- K. For patients who demonstrated no “good faith” effort to pay on their account with a balance of thirty-five (\$35) dollars or more and sixty (60) days or more past due, NHCHD will submit necessary information to the New Hanover County (NHC) Finance Office for the purpose of collecting such outstanding debt. NHC Finance Office will pursue payment of such outstanding debt through their internal collection process, Small Claims Court or through the North Carolina Local Government Debt Set-off Program. An administrative penalty of \$15.00 may be applied to delinquent patient accounts that are sent to NHC Finance Office for processing. Patient statements will inform patient of this fee. Exception to this rule is Family Planning. Payment arrangements will be made for unpaid balances for Family Planning services.
- L. A self-pay patient categorized as a 60% or greater on the sliding fee scale, with a previous bad debt write off will not be allowed to charge services unless a payment is made toward their previous balance and other payment arrangements are agreed upon. Exception to this rule is Family Planning. Payment arrangements will be made for all outstanding bad debt and any current unpaid balances for Family Planning services.

- M. A self-pay patient categorized as a 40% or below on the sliding fee scale, with a previous bad debt write off will not be denied services but their account will be reactivated.
- N. North Carolina State Law prohibits charging patients for the following: Administration of vaccines (IMM) required by law; examination and treatment of STDs; and examination and treatment of tuberculosis (TB).
- G.S. 130A-153(a) prohibits charging patients for administration of vaccines required by law;
  - G.S. 130A-162 prohibits charging patients for examination and treatment of V.D. patients; and
  - G.S. 130A-178(a) prohibits charging patients for examination and treatment of tuberculosis patients, suspects and contacts.

The above general statutes were referenced in a letter from Dr. Ronald H. Levine, State Health Director dated March 8, 1984.

If patients receiving state mandated services (STD/ TB/ IMM) have insurance coverage, their insurance company will be billed the established fee unless the breach of confidentiality statement is signed by the patient requesting that third party billing not occur (Authorization and Assignment of Benefits Form, Page 41). If there is a balance remaining after payment is received from the insurance company, the patient will not be billed for this balance.

All laboratory tests processed by the State Laboratory will be provided at no charge to patients with the exception of Pap Smear (CPT 88175 90). Communicable Disease Control Program guidelines must be adhered to when tests are ordered.

Maternity Care Coordination, Child Service Coordination, Maternal Outreach, Intensive Home Visiting and Childbirth Classes will be billed to Medicaid. For Non-Medicaid patients, Childbirth Classes will be billed to the client at the Medicaid reimbursement rate and placed on a sliding fee scale. Clients must provide proof of income to determine fee eligibility. For non-Medicaid clients, payment for Childbirth class is required at the time of service.

Targeted Case Management will be billed to Medicaid and appropriate third party payors. For Non-Medicaid patients, these services will be billed to state grants. Medicaid and grant billing will be processed through the Children's Developmental Service Agency (CDSA) as outlined in the Consolidated Agreement Between the North Carolina Division of Public Health and Local Health Departments for the Provision of Infant-Toddler Program Services by a Local Health Department. Billing to other third party payors will be processed by NHCHD.

All Childhood Lead Poisoning Prevention Program services will be billed to state grants.

- O. If an insurance company pays for services rendered and payment is sent directly to the patient; the patient is responsible for payment to the NHCHD. In such instances, services may be restricted until said payment is received by the NHCHD. Exceptions to this rule are Family Planning services and those services provided to patients per State laws (see N. Page 11).
- P. Reimbursable visits, for patients with insurance coverage, will be billed to the insurance company. If there is a balance remaining after the insurance payment is received by NHCHD, the entire balance will be billed to the patient, unless otherwise mandated by law or through the Consolidated Agreement between the State of North Carolina and the New Hanover County Health Department.
- Q. Bad debt write-off policies have been established (Page 40).
- R. Fees, based on current cost or purchase of supplies, may be adjusted by the Health Director. New services may be added upon approval by the Health Director if the annual revenues for the service are not expected to exceed \$5,000.
- S. Tests or vaccines recommended or required as part of the Employee Health Program will be administered at no charge to NHCHD employees or volunteers (third party payment will apply). For other purchased vaccines the Health Director may establish reduced charges.
- T. New Hanover County employees may purchase certain in-stock medications, at a reduced price, for themselves, their spouses, and their dependent children.
- U. All clinic and in-house laboratory fees will be collected as part of the check-out process by the NHCHD Billing Clerk. Laboratory fees for self-pay patients receiving out-sourced testing will be collected by the NHCHD Billing Clerk. Out-sourced testing for patients with Medicaid or other third party insurance will be billed directly by the private laboratory. The private laboratory will bill patients for any remaining balances according to their standard fees.
- V. The Health Director, or designee, has the authority to waive or reduce fees for special projects or targeted populations.
- W. Donations may be accepted from any patient regardless of income status as long as they are truly voluntary. There should be no “schedule of donations”, bills for donations, or implied or overt coercion.

- X. Code 99211N will be used to capture services provided that are non-billable. Examples include medication pick-ups in Neurology Clinic, as well as, Community Outreach services such as medication refills; blood pressure checks; weight checks; Information distribution at health fairs; services provided through the Ministering Circle, and quarterly reviews conducted for Adult Day Care Centers.
- Y. Upon receipt from the State, use of new Federal Poverty Levels (FPL) will be automatically implemented, as they apply to our various programs. Currently, our WIC program uses 185% of FPL; Women's Preventive Health, Colposcopy Clinic (non-BCCCP patients), Mobile Dental Unit and BCCCP/Wise Woman use 250% of FPL; and other select clinic services use 350% of FPL.
- Z. Customers registering for car seat classes must pay a \$20.00 registration fee at the time they schedule their classes. When the customers attend the classes, the payments for their registration fees are then applied towards the fees for their car seats. If a customer cancels and reschedules for another class, the fee will be applied towards the future class. However, if the customer fails to cancel prior to the class, the fee is non-refundable.

## II. Program Specific Information

### A. Environmental Charges – Water Bacteriology

1. Samples collected by the Environmental Health division will be charged and the fee collected in the Environmental Health section.
2. On an as needed basis, the Environmental Health clerk will submit a report to the Laboratory Director listing total water sample revenues for the designated time period.
3. Fees for water samples not collected by the Environmental Health Division will be processed by the NHC Health Department Billing Unit.
4. Checks will be received by the Support Services Division and deposited to the appropriate account.

### B. Women's Preventive Health

1. The WPH Program has established a method of directly assessing patient charges and collecting payments for clinical services in accordance with Title X regulations and the fee policy as established by New Hanover County Board of Health.

2. There will be no minimum fee requirement or surcharge that is indiscriminately applied to all patients.
3. Full charges will be assessed if patient income falls at or above 250% of the Federal Poverty Level. Patient's declaration of income shall be accepted for Family Planning patients receiving services in the Women's Preventive Health Program.
4. Un-emancipated minors seeking confidential services are "a family of one" and are to be considered on the basis of their own resources. In such cases, the minor's income must still be reported through the patient data system. Third-party sources (e.g. Insurance, Title XIX) should be billed the established fee if eligibility criteria are met unless the breach of confidentiality statement is signed by the patient requesting that third party billing not occur (Authorization and Assignment of Benefits Form, Page 41). Charges to emancipated minors will be based on the local fee schedule.
5. Charges may be made for supplies not required by the plan of contraceptive care based on cost of supplies. Charges for extra cycles of pills may also be made. Charges for family planning services, to include supplies, will be billed based on sliding fee scale. However, non-family planning services will be charged according to locally established fee schedule and will apply to all patients (Pages 17-25).
6. The NHCHD Socio-Economic Data and Income Form (Page 41) is prepared from verified income information. Patient fee is determined using DEHNR Maternal & Child Health sliding fee scale (Page 34).
7. It is illegal for fees collected in family planning to be put in any fund other than a separate WPH account for use in the local WPH Program.\*\*

\*\* \_\_\_\_\_ Re: U.S. Department of Human and Health Services Public Health Service, D.H.H.S. Publication (OASH) 82-50,00 pg. 25, Found in Codified Fed. Reg. for FP #420FR59.5 (s) (8).

#### C. Laboratory

1. The Laboratory will initiate the NHCHD encounter form on private provider's patients. The encounter form lists all services provided. All services to be rendered will be indicated on the form.
2. The patient will be directed to the billing clerk.

D. Child Health Services

1. Children seen for Child Health Services will be charged in accordance with the NHCHD Sliding Fee Scale (Page 35) with the exception of Limited Physical Examinations.

E. Limited Physical Examinations

Limited physical examinations for such needs as sports, employment, camp, colleges, daycare, foster care, scouts, and head start programs are offered as an option to patients. These physicals will be provided at a flat rate per each type of physical examination, determined by the amount of lab tests and special screenings required. Patients shall be offered the option of a Limited Physical Examination at a flat fee for the service, or to receive an initial/periodic Comprehensive Preventative Medicine Evaluation and Management visit that will be billed to Medicaid or third party insurance or paid by patient based on the sliding fee scale.

### III. Accounts Receivable

The Accounts Receivable Bookkeeping System includes:

1. The fee policy will be explained to each patient with explanations of purpose and details of procedure when the patient presents for services. Each patient is given an opportunity to pay and every effort will be made by the staff to collect total or partial payment or co-pay for third party billing on the day of the visits. Applicable deductible and co-insurance will be billed to the patient upon receipt of insurance Explanation of Payment. Payment in full is required for flat fee services with the exception of flu, pneumonia, and meningococcal vaccines not provided by the State for Medicaid, Medicare, and Health Choice recipients and vaccines not provided by the State for BCBS recipients.
2. Provided that patient confidentiality is not jeopardized, bills showing total charges (less sliding scale discount) will be mailed to patients 45 days after their visit. Two additional statements with balance owed will be mailed if no payment or partial payment is made. Note: As previously identified in Section I, General Guidelines, Item K; for patients who demonstrated no “good faith” effort to pay on their account with a balance of thirty-five (\$35) dollars or more and sixty (60) days or more past due, NHCHD will submit necessary information to the New Hanover County (NHC) Finance Office for the purpose of collecting such outstanding debt. Additionally, such patient accounts will be flagged within our

patient care management database as being in a collection status. An administrative penalty of \$15.00 may be applied to delinquent patient accounts that are sent to NHC Finance Office for processing. Patient statements will inform patient of this fee. Exception to this rule is Family Planning. Payment arrangements will be made for unpaid balances for Family Planning services.

3. Patients with account balances who have demonstrated no “good faith” effort to pay will be subject to service restrictions. Service restrictions will be at the discretion of the Health Director or designee and may include prioritizing or restricting appointments. Exception to this rule is Family Planning. Payment arrangements will be made for unpaid balances for Family Planning services.

## CPT CODES & FEES

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
<b>New Patient:</b>	99201	New Pt Level I - Minimal	\$63.00
	99202	New Pt Level II - Problem Focus	\$94.00
	99203	New Pt Level III - Expanded	\$133.00
	99204	New Pt Level IV - Detailed	\$195.00
	99205	New Pt Level V - Comprehensive	\$245.00
	99381	Well Exam <1	\$120.00
	99382	1-4 Yr Exam	\$130.00
	99383	5-11 Yr Exam	\$154.00
	99384	12-17 Yr Exam	\$169.00
	99385	18-39 Year Exam	\$167.00
	99386	40 - 64 Year Exam	\$199.00
	99387	Over 65 Year Exam	\$215.00
<b>Established Patient:</b>	99211	Est Pt Level I - Minimal	\$35.00
	99212	Est Pt Level II - Problem Focus	\$57.00
	99213	Est Pt Level III - Expanded	\$79.00
	99214	Est Pt Level IV - Detailed	\$123.00
	99215	Est Pt Level V - Comprehensive	\$183.00
	99391	Well Exam <1	\$91.00
	99392	1-4 Yr Exam	\$101.00
	99393	5-11 Yr Exam	\$126.00
	99394	12-17 Yr Exam	\$146.00
	99395	18-39 Yr Exam	\$142.00
	99396	40 - 64 Year Exam	\$158.00
	99397	Over 65 Year Exam	\$175.00
<b>Counseling:</b>	90801	Psychiatric Diagnostic Interview Exam	\$180.00
	90802	INTAC Psy Dx Interview	\$190.00
	90804	Pstx, Office 20-30 min	\$75.00
	90806	Psytx, Office 45-50 min	\$115.00
	90808	Psytx, Office 75-80 min	\$175.00
	90810	Intac Psytx, Office 20-30 min	\$90.00
	90812	Intac Psytx, Office 45-50 min	\$125.00
	90814	Intac Psytx, Office 75-80 min	\$180.00
	90846	Family Psytx w/o patient	\$115.00
	90847	Family Psytx w/patient	\$140.00
	90853	Group Psychotherapy	\$40.00

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	99401	Prev Medical Counseling - 15 Min	\$40.00
	99402	Prev Medical Counseling - 30 Min	\$76.00
	99403	Prev Medical Counseling- 45 Min	\$113.00
	99404	Prev Medical Counseling- 60 Min	\$144.00
	99411	Group Counseling - 30 Min	\$39.00
	99412	Group Counseling - 60 Min	\$68.00
	99420	Admin & Interpretation Health Risk	\$88.00
	99429	Unlisted Preventive Medicine Service	\$0.00
	99361	Medical Conference (30 min)	\$73.00
	99362	Medical Conference (60 min)	\$120.00
<b>Other:</b>	j1055	DepoProvera Injection	\$54.00
	S9442	Childbirth Education Classes (per 1 hr. unit)	\$10.75
	S9445	Maternal Outreach Worker Services (no separate code based on length of contact)	\$16.50
	T1001	Maternal Care Skilled Nurse Home Visit	\$88.00
	T1002	STD Control Treatment	\$19.50
	T1002	TB Control Treatment	\$19.50
	T1016	Child Service Coordination	\$21.74
	T1017	MCC Home Visit (Initial, subsequent, home)	\$29.30
	T1017 HI	Targeted Case Management	\$29.30
	11975	Insert Norplant	\$105.00
	11976	Remove Norplant	\$197.11
	11977	Remove/Reinsert Norplant	\$205.00
	46900	Destroy Anal Lesion(s)	\$240.00
	54050	Destruction/Lesion/Condyloma	\$134.04
	56501	Destroy Vulva Lesion (s)	\$150.00
	57170	Diaphragm Fitting	\$110.00
	57452	Colposcopy w/o Biopsy	\$150.00
	57454	Colposcopy w/Biopsy	\$220.00
	57505	Endocervical curettage	\$125.00
	57456	Colposcopy w/endocervical curettage	\$200.00
	58301	IUD Removal	\$120.00
	71010	* Chest X-Ray/PA	\$40.00
	71020	* Chest X-Ray/PA & Lat	\$70.00
	71021	* Chest X-Ray/Lordotic	\$50.00
	86580	* TB Intradermal Test	\$10.00
	92551	Pure Tone Audiometry, air	\$30.00
	92587	OAE Hearing Screening	\$70.00

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	96110	Developmental Test/ Limited	\$33.00
	96152	Intensive Psychosocial Counseling	\$30.00
	99172	Vision acuity Screening – Color	\$30.00
	99173	Vision Acuity Screening	\$30.00
	99501	Postpartum Assessment Home Visit	\$60.00
	99502EP	Newborn EPSDT Screen Home Visit	\$90.00
	99502	Newborn Assessment Home Visit	\$60.00
	90281	Immune Globulin	\$30.00
<b>IMM:</b>	90281 52	Immune Globulin Admin Fee	\$20.00
	90465 EP	IMM Admin Fee- Children under 8 years	\$27.42
	90467	Imm Adm Fee/Intranasal/oral/<8/MD Counsel	\$15.00
	90467EP	Imm Adm Fee/Intranasal/oral/<8/MD Counsel	\$15.00
	90468	Imm Adm Fee/Inj + Intranasal/oral/<8/MD Co	\$10.00
	90468EP	Imm Adm Fee/Inj + Intranasal/oral/<8/MD Co	\$10.00
	90471	IMM Administration Single Dose	\$18.50
	90471 EP	IMM Administration Single Dose – Health Check	\$27.42
	90472	IMM Administration( Single charge for all add. doses)	\$18.50
	90473	Imm Adm Fee/Intranasal/oral	\$20.00
	90473EP	Imm Adm Fee/Intranasal/oral/<21	\$15.00
	90474	Imm Adm Fee/Inj + Intranasal/oral	\$10.00
	90474EP	Imm Adm Fee/Inj + Intranasal/oral/<21	\$10.00
	90632	* HEP-A vaccine, adult, IM	\$85.00
	90633	* HEP A Pediatric / Adolescent	\$25.00
	90633 52	* HEP A Admin Fee	\$20.00
	90636	* HEP A / B Combination Vaccine	\$120.00
	90636 52	* HEP A/B Combination Vaccine Admin Fee	\$20.00
	90647 52	*PEDVAX	\$20.00
	90648 52	*ACT HIB / OMNI HIB	\$20.00
	90649	*Gardasil	\$165.00
	90649 52	*Gardasil Admin Fee	\$20.00
	90657	* Flu (Child - 6 - 35 months)	\$12.50
	90657 52	*Flu vaccine Admin Fee	\$20.00
	90658	* Flu (Adult / 3 years+)	\$12.50
	90658 52	*Flu vaccine	\$20.00
	90660	Flu Mist (\$43.00 90660+90473)	23.00
	90660 52	*FluMist Intranasal Vaccine	\$20.00
	90665	* Lyme Disease vaccine, IM	\$55.00

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	90669	*Pevnar Vaccine (Add 90471 for total of \$125)	\$106.50
	90669 52	*Pevnar Admin Fee	\$20.00
	90675	* Rabies vaccine (Intramuscular)	\$220.00
	90680	*Rotateq Vaccine (Add 90471 for total of \$98.00)	\$80.50
	90680 52	*Rotateq Admin Fee	\$20.00
	90691	*Typhoid Injectable	\$52.00
	90696 52	Kenrix (Dtap, IPV)	\$20.00
	90698 52	Pentacel (Dtap, IPV, Hib)	\$20.00
	90700 52	*DTAP vaccine IM	\$20.00
	90702 52	*DT vaccine IM	\$20.00
	90707	* MMR virus vaccine SC/jet	\$70.00
	90707 52	*MMR virus vaccine SC/jet Admin Fee	\$20.00
	90710 52	*MMRV (MMR/Varicella) Admin Fee	\$20.00
	90713	*Poliomyelitis vaccine SC	\$40.00
	90713 52	*Poliomyelitis vaccine SC Admin Fee	\$20.00
	90714 52	*Td Tetanus/Diph. Admin Fee	\$20.00
	90715	*Tdap (Tetanus, diphtheria, pertussis) vaccine	\$45.00
	90715 52	*Tdap vaccine Admin Fee	\$20.00
	90716	* Chicken Pox Vaccine	\$105.00
	90716 52	*Chicken Pox Vaccine Admin Fee	\$20.00
	90717	*Yellow Fever	\$100.00
	90723 52	*Pediarix Admin Fee	\$20.00
	90732	* Pnueumococcal vaccine	\$29.50
	90732 52	*Pnueumococcal vaccine Admin Fee	\$20.00
	90733	* Menomune Vaccine	\$115.00
	90734	* Menactra Vaccine	\$115.00
	90734 52	*Menactra Vaccine (state provided admin fee)	\$20.00
	90738	*Japanese Encephalitis	\$210.00
	90736	*Zostavax	\$175.00
	90744 52	*HEP-B Vaccine PED/Apl IM under 11	\$20.00
	90745 52	*HEP-B Adolescent/ Ped High Risk (11-19)	\$20.00
	90746	*HEP-B vaccine, over 20 IM	\$75.00
	90746 52	*HEP-B vaccine, over 20 IM	\$20.00
	95115	* Immunotherapy, one injection	\$5.00
	95117	* Immunotherapy injections	\$10.00
	96372	* Injection (SC) / (IM)	\$5.00
	G0008	Medicare Administration Fee (FLU)	\$18.50

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	G0009	Medicare Administration Fee (Pneu)	\$18.50
<b>House Labs:</b>	36415	Venipuncture	\$14.00
	36416	Fingerstick	\$14.00
	80048	Basic Metabolic Panel	\$15.00
	80051	Electrolite Panel	\$15.00
	80053	Comp Metabolic Panel	\$15.00
	80061	Lipid Panel	\$25.00
	80069	Renal Panel	\$20.00
	80076	Hepatic Panel	\$15.00
	80188	Mysoline/Primidone Level	\$48.00
	81001	Urinalysis, auto, w/microscopic	\$12.00
	81003	Urinalysis, auto, without microscopic	\$8.00
	81025	Urine Pregnancy Test	\$11.00
	82040	Albumin	\$15.00
	82120	Amines- Wet Mount	\$ 10.00
	82150	Amylase	\$15.00
	82247	Bilirubin, Total	\$15.00
	82248	Billirubin, Direct	\$15.00
	82270	Test Feces Blood (Occult Bld)	\$10.00
	82465	Assay Serum Cholesterol	\$15.00
	82550	CK	\$20.00
	82553	MB	\$20.00
	82728	Ferritin	\$25.00
	82746	Folic Acid	\$25.00
	82947	Glucose, quantitative	\$15.00
	82565	Assay Creatinine	\$15.00
	82948	Glucose, quantitative,blood, reagent strip	\$20.00
	83036	Hemoglobin A1C	\$20.00
	83540	Iron	\$15.00
	83550	TIBC (Iron Binding Cap)	\$15.00
	83615	Lactate (LD) (LDH) Enzyme	\$15.00
	83718	Lipoprotein (HDL)	\$15.00
	84075	Assay Alkaline Phosphate	\$15.00
	84152	PSA	\$35.00
	84175	Protein, Total	\$15.00
	84436	T4, Total	\$15.00
	84439	T4, Free	\$20.00

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	84443	TSH	\$30.00
	84450	SGOT/AST	\$15.00
	84460	SGPT/ALT	\$15.00
	84478	Triglycerides	\$15.00
	84480	T3, Total	\$25.00
	84520	Bun	\$15.00
	84703	Serum Pregnancy Test	\$20.00
	85025	Complete CBC with Diff	\$15.00
	85027	Coulter Hematology Profile	\$13.00
	85018	Hemoglobin	\$10.00
	85651	RBC SED Rate, Non-auto	\$15.00
	86308	Mono Test	\$15.00
	86592	Serology, qualitative (trust)	\$18.00
	86593	Serology, quantitative (trust)	\$15.00
	86803	Hepatitis C Antibody	\$25.00
	87070	Culture (including throat, GC, wound)	\$15.00
	87081	Culture, GC, screening only (FP)	\$ 20.00
	87086	Urine Culture, plating and colony count	\$15.00
	87184	Susceptibility Studies	\$15.00
	87210	Wet Smear	\$15.00
	87205	Gram Stain (Wound culture)	\$15.00
	87880	Strep A Kit	\$40.00
<b>Referred Labs:</b>	80048 90	Basic Metabolic Panel (Private Lab)	NC/HF
	80051 90	Electrolite Panel (Private Lab)	NC/HF
	80053 90	Comp Metabolic Panel (Private Lab)	NC/HF
	80061 90	Lipid Panel (Private Lab)	NC/HF
	80069 90	Renal Panel (Private Lab)	NC/HF
	80076 90	Hepatic Plan (Private Lab)	NC/HF
	80156 90	Assay Carbamazepine (Cherry Hospital)	NC
	80164 90	Valproic Acid (Cherry Hospital)	NC
	80168 90	Assay for Ethosoximide (Cherry Hospital)	NC
	80184 90	Assay for Phenobarbital (Cherry Hospital)	NC
	80185 90	Assay for Phenytoin (Cherry Hospital)	NC
	80188 90	Assay for Primidone	NC/HF
	82040 90	Albumin (Private Lab)	NC/HF
	82150 90	Amylase (Private Lab)	NC/HF
	82247 90	Billirubin, Total (Private Lab)	NC/HF

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	82248 90	Billirubin, Direct (Private Lab)	NC/HF
	82465 90	Assay Serum Cholestrol (Private Lab)	NC/HF
	82550 90	CK (Private Lab)	NC/HF
	82553 90	MB (Private Lab)	NC/HF
	82565 90	Assay Creatinine (Private Lab)	NC/HF
	82728 90	Ferritin (Private Lab)	NC/HF
	82746 90	Folic Acid (Private Lab)	NC/HF
	82760 90	Assay Galactose (Newborn) (State Lab)	NC
	82947 90	Glucose, quantitative (Private Lab)	NC/HF
	83020 90	Hemoglobin Electrophorsis (State Lab)	NC
	83036 90	Hemoglobin A1C (Private Lab)	NC/HF
	83498 90	17-OH-P (Newborn) (State Lab)	NC
	83540 90	Iron (Private Lab)	NC/HF
	83550 90	TIBC (Iron Binding Cap) (Private Lab)	NC/HF
	83615 90	Lactate (LD)(LDH) Enzyme (Private Lab)	NC/HF
	83655 90	Blood Lead (State Lab)	NC
	83718 90	Lipoprotein (HDL) (Private Lab)	NC/HF
	84030 90	Assay Blood PKU (State Lab)	NC/NC
	84075 90	Assay Alkaline Phosphate (Private Lab)	NC/HF
	84152 90	PSA (Private Lab)	NC/HF
	84175 90	Protein, Total (Private Lab)	NC/HF
	84436 90	T4, Total (Private Lab)	NC/HF
	84437 90	Assay Total Thyroxine (Newborn) (State Lab)	NC
	84439 90	T4, Free (Private Lab)	NC/HF
	84443 90	TSH (Private Lab)	NC/HF
	84450 90	SGOT / AST (Private Lab)	NC/HF
	84460 90	SGPT ALT (Private Lab)	NC/HF
	84478 90	Triglycerides (Private Lab)	NC/HF
	84480 90	T3, Total (Private Lab)	NC/HF
	84520 90	BUN (Private Lab)	NC/HF
	84703 90	Serum Pregnancy Test (Private Lab)	NC/HF
	85651 90	RBC SED Rate, Non-auto (Private Lab)	NC/HF
	86308 90	Mono Test (Private Lab)	NC/HF
	86618 90	Lyme Disease Antibody	NC
	86666 90	Ehrlichia Antibody	NC
	86701 90	HIV- (State Lab)	NC
	86709 90	HEP A IGM (Antibody) (Private Lab)	NC

Clinic / Service	CPT / Medicaid Codes	CPT / Medicaid Description	NHCHD Fees
	86757 90	Rickettsia Antibody (Rocky Mt Spotted Fever)	NC
	86781 90	Treponema pallidum confirm (State Lab)	NC
	86803 90	Hepatitis C Antibody (Private Lab)	NC/HF
	87045 90	Stool Culture (State Lab)	NC
	87077 90	Nose, throat, bacteria culture (State Lab)	NC/HF
	87116 90	Culture, tubercle or other acid fast bacilli (State Lab)	NC
	87118 90	Mycobacteria identification (State Lab)	NC
	87177 90	Ova & Parasites Smears (State Lab)	NC
	87206 90	Smear, Stain Interpret (TB Smear) (State Lab)	NC
	87252 90	Virus Inoculation for Test (Herpes) (State Lab)	NC
	87285 90	Treponema Pallidum (State Lab)	NC
	87340 90	HEP B Surface ag,E/A (State Lab)	NC
	87491 90	Chlamydia, nucleic acid (State Lab)	NC
	87591 90	NAAT Gonorrhea (State Lab)	NC
	88175 90	Pap Smear (State Lab)	12.33
	99000	Handling Fee (One per visit)	18.00
<b>Nutrition:</b>	97802	Initial Assessment Med Nutrition Therapy	\$100.00
	97803	Re-Assessment Med Nutrition Therapy (15 min)	\$22.50
	97803	Re-Assessment Med Nutrition Therapy (30 min)	\$45.00
	97803	Re-Assessment Med Nutrition Therapy (45 min)	\$67.50
	97803	Re-Assessment Med Nutrition Therapy (60 min)	\$90.00
<b>Miscellaneous:</b>	MRI	* Med Record for Ins (per Ins reimbursement)	varies
	FAXL	* Local Fax (per page)	\$1.00
	FAXLD	* Long Distance Fax (per page)	\$2.00
	ADM	* Off- Site Administrative Charge	\$5.00
		* Returned Check Fee	\$25.00
	99071	Provision of Patient Supplies & Education	N/C
	N/A	Car Seat Class - Registration Fee	\$20.00
	N/A	Car Seat (If car seat class was attended, registration fee is applied to car seat charge.)	\$40.00
<b>WPH Supplemental Fees:</b>	303	Miconazole Vaginal Cream (per tube)	\$8.00
	FCZ150	Fluconazole, 150mg/each	\$2.00
	LU235	Replacement Oral Contraceptive (per cycle)	10.00
		Ortho Evra	\$27.00
	DIAR	Replacement Diaphragm (each)	\$10.00
<b>Medications:</b>		* Typhoid capsule bottle of 4	\$50.00
		* Chloroquine (500 mg) one dose	\$4.00
<b>Clinic / Service</b>	<b>CPT /</b>	<b>CPT / Medicaid Description</b>	<b>NHCHD</b>

	<b>Medicaid Codes</b>		<b>Fees</b>
		* Chloroquine (250 mg) one dose	\$2.00
		* Malarone pediatric one dose	\$2.00
		* Malarone adult one dose	\$5.00
		* Doxycycline 50 mg each	\$0.10
		* Docycycline 75 mg each	\$4.00
		* Docycycline 100 mg each	\$0.10
<b>NHC Employees/Available Medications</b>	EMPFM	* Delfen Foam (each)	\$12.00
	FCZ150E	Fluconazole 150 mg each	\$2.00
	664E	* Prenatal Vitamins (per package)	\$12.00
	303E	* Miconazole Vaginal Cream (per tube)	\$8.00
	EBCP	* Norinyl 1+35 (per cycle)	\$10.00
	EBCP	* Desogen (per cycle)	\$10.00
	EBCP	* Ortho-Novum 7-7-7 (per cycle)	\$10.00
	EBCP	* Ortho Novum 1/35 (per cycle)	\$10.00
	EBCP	* Ortho Tricyclen (per cycle)	\$10.00
	EBCP	* Ortho Tricyclen Lo (per cycle)	\$10.00
	EBCP	* Lo-Ovral (per cycle)	\$10.00
	EBCP	* Micronor (per cycle)	\$10.00
	EBCP	*Microgestin FE (per cycle)	\$10.00
	DIARE	*Replacement Diaphragm (each)	\$10.00

HF= Add Handling Fee

NC= No Charge

NC/HF = No Charge Lab/Add Handling Fee

\* Flat Rate Charged – Sliding fee scale does not apply to these services.

**State-Approved Local Codes  
Revised 03/09**

<b>NEW Local Code</b>	<b>Description</b>	<b>NHCHD Fee</b>
LU001	Lab specimen obtained for f/u of newborn screening	NC
LU002	Lice Treatment (e.g., Nix)*	Future Use
LU003	Suture removal without anesthesia	Future Use
LU008	Infant Feeding Class	Future Use
LU009	AHA Heart Saver Class	Future Use
LU010	AHA Health Care Providers CPR	Future Use
LU011	Health Promotion/Prevention Package for Industry, civic groups, etc.	Future Use
LU012	Smoking Cessation Program	Future Use
LU013	Glucometer Calibration	NC
LU016	Structured Exercise Program	Future Use
LU017	Completion of Disability Verification/Disability Leave Form	NC
LU018	Copy of Medical Record	\$5.00
LU019	Education and Outreach to Latino Population	NC
LU020	Menu Planning (development/review for compliance with standards for schools, day cares, nursing homes, etc.)	NC
LU021	Completion of form verifying exam (not at time of exam or other billable service)	NC
LU022	Immunization Status Review for WIC; no vaccines needed	NC
LU023	Diabetic Teaching	NC
LU024	Determination of Presumptive Eligibility	NC
LU100	HIV Pre-Test Counseling and Testing (REPORT ONLY)	NC
LU101	HIV Post-Test Results and Counseling (REPORT ONLY)	NC
LU102	Completion of "Record of Tuberculosis Screening" – DHHS 3405	\$10.00
LU114	PPD with State-Supplied vaccine (REPORT ONLY)	NC
LU115	Contraceptive Patch Replacement	Future Use
LU116	NuvaRing Replacement	Future Use
LU117	PPD, Positive Result – Contact (REPORT ONLY)	NC
LU118	PPD, Negative Result – Contact (REPORT ONLY)	NC
LU119	PPD, Positive Result – Non-contact (REPORT ONLY)	NC
LU120	PPD, Negative Result – Non-contact (REPORT ONLY)	NC
LU121	TB Directly Observed Therapy (DOT)	NC
LU122	TB Directly Observed Preventive Therapy (DOPT)	NC
LU123	PPD, Not Read – Contact (REPORT ONLY)	NC
LU124	PPD, Not Read – Non-contact (REPORT ONLY)	NC
LU201	Repeat Pap Smear (REPORT ONLY)	NC
LU202	Limited Interview: International Travel	\$35.00
LU203	Limited Physical: Employment **	\$35.00
LU204	Limited Physical: DOT	Future Use
LU205	Limited Physical: Dare Challenge	Future Use
LU206	Limited Physical: Day Care**	\$35.00
LU207	Limited Physical: Head Start**	\$65.00
LU208	Limited Physical: Sports**	\$35.00
LU209	Limited Physical: Foster Care**	\$35.00
LU210	Limited Physical: Camp**	\$35.00
LU211	Limited Physical: Scouts**	\$35.00
LU212	Limited Physical: College**	\$65.00
LU213	Limited Physical: Respirator	Future Use

LU215	Limited Physical: DSS	Future Use
LU216	Limited Physical: County Employee	Future Use
LU217	Limited Physical: Senior Companion	Future Use
LU218	Limited Physical: DOC	Future Use
LU219	Limited Physical: US Forest Service	Future Use
LU230	Blood Pressure Check*	NC
LU231	Pap Smear and Breast Assessment only ** (for non-BCCCP eligibles per age or income)	NC
LU232	Test/Lab Results only visit (REPORT ONLY)	NC
LU233	Condom Provision and counseling (REPORT ONLY)	NC
LU234	Sterilization Counseling (REPORT ONLY)	NC
LU235	Pill Replacement (REPORT ONLY)	\$10.00
LU236	Pill Pick-up (REPORT ONLY)	NC
LU237	Non-billable Social Worker contact (REPORT ONLY)	NC
LU238	Non-billable Health Education contact (REPORT ONLY)	NC
LU239	Non-billable Nutritionist contact (REPORT ONLY)	NC
LU240	Non-billable TB LPN Contact (REPORT ONLY)	NC
LU241	Non-billable Child Health Nurse Contact (REPORT ONLY)	NC
LU242	Non-billable STD Contact (REPORT ONLY)	NC
LU243	Non-billable Communicable Dx Contact (REPORT ONLY)	NC
LU244	Non-billable Interpreter Service (REPORT ONLY)	NC
LU245	Clinical Dental Varnish for 3-6 year olds	Future Use
LU 246	Tubal Ligation Counseling /obtain consent	NC
LU 247	Non-Billable MH Nurse Contact (REPORT ONLY)	NC

- \*Note: If components of an office visit are done, then this service should be billed using the appropriate level of E & M code (e.g. 99211). *These local codes would not be billable to the patient in addition to the E & M code.*
- \*\*Note: If any exam of this type is billed to Medicaid or other third party using a CPT or HCPCS code, then ALL exams of this type must be billed using that code and *the local codes may not be used to differentiate fees for the same service billed to patients as opposed to third party payors.*

**Mobile Dental Unit Fees  
(Includes Sliding Fee Scale)**

<b>CPT Code</b>	<b>Description</b>	<b>F.A.C.T. Rates Approved</b>	<b>60% SFS</b>	<b>80% SFS</b>	<b>100% SFS</b>
D0120	Periodic oral evaluation	\$29.71	\$17.83	\$23.77	\$29.71
D0140	Limited oral evaluation - problem focused	\$39.35	\$23.61	\$31.48	\$39.35
D0150	Comprehensive oral evaluation - new/established patient	\$49.50	\$29.70	\$39.60	\$49.50
D0160	Detailed/extensive oral evaluation - problem focused, by report	\$65.34	\$39.20	\$52.27	\$65.34
D0210	Intraoral - complete series (including bitewings)	\$82.71	\$49.63	\$66.17	\$82.71
D0220	Intraoral - periapical first film	\$16.06	\$9.64	\$12.85	\$16.06
D0230	Intraoral - periapical each additional film	\$12.85	\$7.71	\$10.28	\$12.85
D0240	Intraoral - occlusal film	\$16.71	\$10.03	\$13.74	\$16.71
D0270	Bitewing - single film	\$11.86	\$7.11	\$9.49	\$11.86
D0272	Bitewings - two films	\$19.27	\$11.56	\$15.42	\$19.27
D0273	Bitewings - three films	\$26.91	\$16.14	\$21.52	\$26.91
D0274	Bitewings - four films	\$34.53	\$20.72	\$27.62	\$34.53
D0330	Panoramic film	\$63.44	\$38.06	\$50.75	\$63.44
D0470	Diagnostic casts	\$44.88	\$26.93	\$35.90	\$44.88
D1110	Prophylaxis - adult (HC 14+)	\$38.89	\$23.33	\$31.11	\$38.89
D1120	Prophyaxis - child	\$28.05	\$16.83	\$22.44	\$28.05
D1203	Topical application of fluoride (prophylaxis not included) - child	\$16.98	\$10.19	\$13.59	\$16.98
D1204	Topical application of fluoride (prophylaxis not included) - adult (HC 14+)	\$16.98	\$10.19	\$13.59	\$16.98
D1351	Sealant - per tooth	\$32.92	\$19.75	\$26.34	\$32.92
D1510	Space maintainer - fixed - unilateral	\$228.86	\$137.32	\$183.09	\$228.86
D2140	Amalgam 1 surface - primary or permanent	\$69.06	\$41.43	\$55.25	\$69.06
D2150	Amalgam 2 surfaces - primary or permanent	\$87.35	\$52.41	\$69.88	\$87.35
D2160	Amalgam 3 surfaces - primary or permanent	\$100.38	\$60.23	\$80.30	\$100.38
D2161	Amalgam four or more surfaces - primary or permanent	\$110.11	\$66.07	\$88.09	\$110.11
D2330	Resin-based composite - one surface, anterior	\$69.06	\$41.43	\$55.25	\$69.06
D2331	Resin-based composite - two surfaces, anterior	\$85.12	\$51.07	\$68.09	\$85.12
D2332	Resin-based composite - three surfaces, anterior	\$100.38	\$60.23	\$80.30	\$100.38
D2335	Resin-based composite - four or more surfaces or involving incisal angle	\$127.68	\$76.61	\$102.14	\$127.68
D2391	Resin-based composite - one surface, posterior	\$85.12	\$51.07	\$68.09	\$85.12
D2392	Resin-based composite - two surfaces, posterior	\$127.68	\$76.61	\$102.14	\$127.68

D2393	Resin-based composite - three surfaces, posterior	\$164.67	\$98.80	\$131.74	\$164.67
D2394	Resin-based composite - four or more surfaces, posterior	\$201.41	\$120.85	\$161.13	\$201.41
D2930	Prefabricated stainless steel crown - primary tooth	\$158.68	\$95.21	\$126.94	\$158.68
D2931	Prefabricated stainless steel crown - permanent tooth	165.00	\$99.00	\$132.00	\$165.00
D2932	Prefabricated resin crown	\$179.31	\$107.59	\$143.45	\$179.31
D2940	Sedative filling	\$45.82	\$27.49	\$36.65	\$45.82
D2950	Core buildup, including any pins	\$113.19	\$67.91	\$90.55	\$113.19
D2951	Pin retention - per tooth, in addition to restoration	\$27.49	\$16.49	\$21.99	\$27.49
D2970	Temporary crown, fractured tooth	\$146.07	\$86.64	\$116.86	\$146.07
D3220	Therapeutic pulpotomy (excluding final restoration)	\$85.92	\$51.55	\$68.74	\$85.92
D3221	Pulpal Debridement	\$210.00	\$126.00	\$168.00	\$210.00
D3310	Root canal therapy - anterior (excluding final restoration)	\$296.45	\$177.87	\$237.16	\$296.45
D3320	Root canal therapy - bicuspid (excluding final restoration)	\$350.35	\$210.21	\$280.28	\$350.35
D3330	Root canal therapy - molar (excluding final restoration)	\$428.51	\$257.10	\$342.80	\$428.51
D4341	Periodontal scaling/root planing - four or more contiguous teeth per quad	\$105.11	\$63.06	\$84.08	\$105.11
D4355	Full mouth debridement to enable comprehensive evaluation and dx	\$77.62	\$46.57	\$62.09	\$77.62
D7111	Extraction, coronal remnants - deciduous tooth	\$53.90	\$32.34	\$43.12	\$53.90
D7140	Extraction, erupted tooth or exposed root	\$66.55	\$39.93	\$53.24	\$66.55
D7210	Surgical removal of erupted tooth	\$114.40	\$68.64	\$91.52	\$114.40
D7220	Removal of impacted tooth, soft tissue	\$129.90	\$77.94	\$103.92	\$129.90
D7230	Removal of impacted tooth, partially bony	\$174.46	\$104.68	\$139.57	\$174.46
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$124.51	\$74.71	\$99.61	\$124.51
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed/displaced	\$220.99	\$132.59	\$176.79	\$220.99
D7286	Biopsy of oral tissue - soft (all others)	\$124.63	\$74.78	\$99.70	\$124.63
D7510	Incision and drainage of abscess - intraoral soft tissue	\$167.88	\$100.73	\$134.30	\$167.88
D9110	Palliative (ER) treatment of dental pain - minor procedure	\$49.05	\$29.43	\$39.24	\$49.05
D9220	Deep sedation/general anesthesia - first 30 minutes	\$155.77	\$93.46	\$124.62	\$155.77
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$49.50	\$29.70	\$39.60	\$49.50
D9630	Other drugs and/or medicaments, by report	\$17.51	\$10.51	\$14.01	\$17.51

**NEW HANOVER COUNTY HEALTH DEPARTMENT**  
**FEE POLICY**

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New Hanover County Health Department

**PATIENT'S BILL OF RIGHTS**

1. The **PATIENT** has the right to considerate and respectful care.
2. The **PATIENT** has the right to obtain from his/her medical provider complete and current information concerning diagnosis and treatment, in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. The patient has the right to know by name the medical provider responsible for coordinating his/her care.
3. The **PATIENT** has the right to receive his/her medical provider information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment and the medically significant risks involved. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The **PATIENT** has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
5. The **PATIENT** has the right to every consideration of his/her privacy concerning his/her own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in direct care must have the permission of the patient to be present.
6. The **PATIENT** has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.
7. The **PATIENT** has the right to expect that within its capacity any agency must make reasonable response to the request of a patient for services. The agency must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another agency only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The agency to which the patient is to be transferred must first have accepted the patient for transfer.
8. The **PATIENT** has the right to obtain information as to any relationship of the agency to other similar agencies and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationship among individuals, by name who is treating him/her.

## **PATIENT'S BILL OF RIGHTS**

9. The **PATIENT** has the right to expect reasonable continuity of care. He/she has the right to know in advance what appointment times and health care providers are available.
10. The **PATIENT** has the right to examine and receive an explanation of his/her bill regardless of source of payment.
11. The **PATIENT** has the right to know what the Health Department rules and regulations are that apply to his/her conduct as a patient.

The New Hanover County Health Department staff provides safe and individual patient care based on each patient's needs and rights through:

- a. recognition of each patient's dignity as a human being, and
- b. defending the rights of each patient as an advocate.

Our goal is to promote and contribute to the highest level of health possible for the citizens of New Hanover County by:

- Identifying and reducing health risks in the County
- Detecting, investigating and preventing the spread of disease
- Promoting healthy lifestyles
- Providing a safe and healthful environment
- Providing quality health care services to those with limited access

The observance of these rights is expected to contribute to quality patient care and greater satisfaction for the patient and health care provider.

FEDERAL POVERTY LEVELS FOR 2009

<u>Family Size</u>	Gross Annual Income
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010
9	\$40,750
10	\$44,490
11	\$48,230
12	\$51,970

N. C. Division of Public Health  
 Women's and Children's Health Section  
 Annual Gross Family Income  
 Sliding Fee Scale --101% to 250% of Poverty  
**Family Planning Waiver Eligibility Included**

Revised 3/2009  
 Effective 7/2009

**Use for Family Planning, Colposcopy & Mobile Dental Unit**

**FP Waiver  
 Eligibility\***

Family Size	Federal Poverty	Partial-Pay Bracket		Partial-Pay Bracket		Partial-Pay Bracket		Partial-Pay Bracket		Full Pay	
		Twenty Percent From	Percent To	Forty Percent From	Percent To	Sixty Percent From	To	Eighty Percent From	Percent To		
1	\$10,830	\$10,831	\$14,891	\$14,892	\$18,953	\$18,954	<b>\$20,036</b>	\$23,014	\$23,015	\$27,074	\$27,075
2	\$14,570	\$14,571	\$20,034	\$20,035	\$25,498	\$25,499	<b>\$26,955</b>	\$30,961	\$30,962	\$36,424	\$36,425
3	\$18,310	\$18,311	\$25,176	\$25,177	\$32,043	\$32,044	<b>\$33,874</b>	\$38,909	\$38,910	\$45,774	\$45,775
4	\$22,050	\$22,051	\$30,319	\$30,320	\$38,588	\$38,589	<b>\$40,793</b>	\$46,856	\$46,857	\$55,124	\$55,125
5	\$25,790	\$25,791	\$35,461	\$35,462	\$45,133	\$45,134	<b>\$47,712</b>	\$54,804	\$54,805	\$64,474	\$64,475
6	\$29,530	\$29,531	\$40,604	\$40,605	\$51,678	\$51,679	<b>\$54,631</b>	\$62,751	\$62,752	\$73,824	\$73,825
7	\$33,270	\$33,271	\$45,746	\$45,747	\$58,223	\$58,224	<b>\$61,550</b>	\$70,699	\$70,700	\$83,174	\$83,175
8	\$37,010	\$37,011	\$50,889	\$50,890	\$64,768	\$64,769	<b>\$68,469</b>	\$78,646	\$78,647	\$92,524	\$92,525
9	\$40,750	\$40,751	\$56,031	\$56,032	\$71,313	\$71,314	<b>\$75,388</b>	\$86,594	\$86,595	\$101,874	\$101,875
10	\$44,490	\$44,491	\$61,174	\$61,175	\$77,858	\$77,859	<b>\$82,307</b>	\$94,541	\$94,542	\$111,224	\$111,225
11	\$48,230	\$48,231	\$66,316	\$66,317	\$84,403	\$84,404	<b>\$89,226</b>	\$102,489	\$102,490	\$120,574	\$120,575
12	\$51,970	\$51,971	\$71,459	\$71,460	\$90,948	\$90,949	<b>\$96,145</b>	\$110,436	\$110,437	\$129,924	\$129,925

**\* at or below  
 185% of federal**

N. C. Division of Public Health  
 Women's and Children's Health Section  
 Annual Gross Family Income  
 Sliding Fee Scale --101% to 350% of Poverty

Revised 3/2009  
 Effective 7/2009

**Use for Adult Health, Child Health, Adult Neurology & Nutrition**

Family Size	Federal Poverty	Twenty Percent From To	Forty Percent From To	Sixty Percent From To	Eighty Percent From To	Full Pay
1	\$10,830	\$10,831 \$17,599	\$17,600 \$24,368	\$24,369 \$31,136	\$31,137 \$37,904	\$37,905
2	\$14,570	\$14,571 \$23,676	\$23,677 \$32,783	\$32,784 \$41,889	\$41,890 \$50,994	\$50,995
3	\$18,310	\$18,311 \$29,754	\$29,755 \$41,198	\$41,199 \$52,641	\$52,642 \$64,084	\$64,085
4	\$22,050	\$22,051 \$35,831	\$35,832 \$49,613	\$49,614 \$63,394	\$63,395 \$77,174	\$77,175
5	\$25,790	\$25,791 \$41,909	\$41,910 \$58,028	\$58,029 \$74,146	\$74,147 \$90,264	\$90,265
6	\$29,530	\$29,531 \$47,986	\$47,987 \$66,443	\$66,444 \$84,899	\$84,900 \$103,354	\$103,355
7	\$33,270	\$33,271 \$54,064	\$54,065 \$74,858	\$74,859 \$95,651	\$95,652 \$116,444	\$116,445
8	\$37,010	\$37,011 \$60,141	\$60,142 \$83,273	\$83,274 \$106,404	\$106,405 \$129,534	\$129,535
9	\$40,750	\$40,751 \$66,219	\$66,220 \$91,688	\$91,689 \$117,156	\$117,157 \$142,624	\$142,625
10	\$44,490	\$44,491 \$72,296	\$72,297 \$100,103	\$100,104 \$127,909	\$127,910 \$155,714	\$155,715
11	\$48,230	\$48,231 \$78,374	\$78,375 \$108,518	\$108,519 \$138,661	\$138,662 \$168,804	\$168,805
12	\$51,970	\$51,971 \$84,451	\$84,452 \$116,933	\$116,934 \$149,414	\$149,415 \$181,894	\$181,895

N. C. Division of Public Health  
 NC BCCCP and WISEWOMAN  
 Annual Gross Family Income  
 Sliding Fee Scale --101% to 250% of Poverty

Revised 4/2009  
 Effective 7/2009

Family Size	Federal Poverty	Twenty From	Percent To	Forty From	Percent To	Sixty From	Percent To	Eighty From	Percent To	Full
1	\$10,830	\$10,831	\$14,891	\$14,892	\$18,953	\$18,954	\$23,014	\$23,015	\$27,074	\$27,075
2	\$14,570	\$14,571	\$20,034	\$20,035	\$25,498	\$25,499	\$30,961	\$30,962	\$36,424	\$36,425
3	\$18,310	\$18,311	\$25,176	\$25,177	\$32,043	\$32,044	\$38,909	\$38,910	\$45,774	\$45,775
4	\$22,050	\$22,051	\$30,319	\$30,320	\$38,588	\$38,589	\$46,856	\$46,857	\$55,124	\$55,125
5	\$25,790	\$25,791	\$35,461	\$35,462	\$45,133	\$45,134	\$54,804	\$54,805	\$64,474	\$64,475
6	\$29,530	\$29,531	\$40,604	\$40,605	\$51,678	\$51,679	\$62,751	\$62,752	\$73,824	\$73,825
7	\$33,270	\$33,271	\$45,746	\$45,747	\$58,223	\$58,224	\$70,699	\$70,700	\$83,174	\$83,175
8	\$37,010	\$37,011	\$50,889	\$50,890	\$64,768	\$64,769	\$78,646	\$78,647	\$92,524	\$92,525
9	\$40,750	\$40,751	\$56,031	\$56,032	\$71,313	\$71,314	\$86,594	\$86,595	\$101,874	\$101,875
10	\$44,490	\$44,491	\$61,174	\$61,175	\$77,858	\$77,859	\$94,541	\$94,542	\$111,224	\$111,225
11	\$48,230	\$48,231	\$66,316	\$66,317	\$84,403	\$84,404	\$102,489	\$102,490	\$120,574	\$120,575
12	\$51,970	\$51,971	\$71,459	\$71,460	\$90,948	\$90,949	\$110,436	\$110,437	\$129,924	\$129,925

**New Hanover County Health Department  
Sliding Fee Scale Rates**

<b>CPT / Medicaid Codes</b>	<b>CPT / Medicaid Description</b>	<b>0%</b>	<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>
	<b>Clinic Services</b>						
11975	Insert Norplant	\$0.00	\$21.00	\$42.00	\$63.00	\$84.00	\$105.00
11976	Remove Norplant	\$0.00	\$39.42	\$78.84	\$118.27	\$157.69	\$197.11
11977	Remove/Reinsert Norplant	\$0.00	\$41.00	\$82.00	\$123.00	\$164.00	\$205.00
46900	Destroy Anal Lesion(s)	\$0.00	\$48.00	\$96.00	\$144.00	\$192.00	\$240.00
54050	Destruction/Lesion/Condyloma	\$0.00	\$26.81	\$53.62	\$80.42	\$107.23	\$134.04
56501	Destroy Vulva Lesion (s)	\$0.00	\$30.00	\$60.00	\$90.00	\$120.00	\$150.00
57170	Diaphragm Fitting	\$0.00	\$22.00	\$44.00	\$66.00	\$88.00	\$110.00
58301	IUD Removal	\$0.00	\$24.00	\$48.00	\$72.00	\$96.00	\$120.00
90801	Psychiatric Diagnostic Interview Exam	\$0.00	\$36.00	\$72.00	\$108.00	\$144.00	\$180.00
90802	INTAC Psy Dx Interview	\$0.00	\$38.00	\$76.00	\$114.00	\$152.00	\$190.00
90804	Psytx, Office 20-30 min	\$0.00	\$15.00	\$30.00	\$45.00	\$60.00	\$75.00
90806	Psytx, Office 45-50 min	\$0.00	\$23.00	\$46.00	\$69.00	\$92.00	\$115.00
90808	Psytx, Office 75-80 min	\$0.00	\$35.00	\$70.00	\$105.00	\$140.00	\$175.00
90810	Intac Psytx, Office 20-30 min	\$0.00	\$18.00	\$36.00	\$54.00	\$72.00	\$90.00
90812	Intac Psytx, Office 45-50 min	\$0.00	\$25.00	\$50.00	\$75.00	\$100.00	\$125.00
90814	Intac Psytx, Office 75-80 min	\$0.00	\$36.00	\$72.00	\$108.00	\$144.00	\$180.00
90846	Family Psytx w/o patient	\$0.00	\$23.00	\$46.00	\$69.00	\$92.00	\$115.00
90847	Family Psytx w/patient	\$0.00	\$28.00	\$56.00	\$84.00	\$112.00	\$140.00
90853	Group Psychotherapy	\$0.00	\$8.00	\$16.00	\$24.00	\$32.00	\$40.00
92551	Pure Tone Audiometry, air	\$0.00	\$6.00	\$12.00	\$18.00	\$24.00	\$30.00
92587	OAE Hearing Screening	\$0.00	\$14.00	\$28.00	\$42.00	\$56.00	\$70.00
96110	Developmental Test/ Limited	\$0.00	\$6.60	\$13.20	\$19.80	\$26.40	\$33.00
96152	Intensive Psychosocial Counseling	\$0.00	\$6.00	\$12.00	\$18.00	\$24.00	\$30.00
97802	Initial Assessment Medical Nutrition Therapy	\$0.00	\$20.00	\$40.00	\$60.00	\$80.00	\$100.00
97803	Re-Assess Medical Nutrition Therapy (15 min)	\$0.00	\$4.30	\$8.60	\$12.90	\$17.20	\$21.50
97803	Re-Assess Medical Nutrition Therapy (30 min)	\$0.00	\$8.60	\$17.20	\$25.80	\$34.40	\$43.00
97803	Re-Assess Medical Nutrition Therapy (45 min)	\$0.00	\$12.90	\$25.80	\$38.70	\$51.60	\$64.50
97803	Re-Assess Medical Nutrition Therapy (60 min)	\$0.00	\$17.20	\$34.40	\$51.60	\$68.80	\$86.00
99172	Vision Acuity Screening- Color	\$0.00	\$6.00	\$12.00	\$18.00	\$24.00	\$30.00
99173	Vision Acuity Screening	\$0.00	\$6.00	\$12.00	\$18.00	\$24.00	\$30.00
99201	New Pt Level I - Minimal	\$0.00	\$12.60	\$25.20	\$37.80	\$50.40	\$63.00
99202	New Pt Level II - Problem Focus	\$0.00	\$18.80	\$37.60	\$56.40	\$75.20	\$94.00
99203	New Pt Level III - Expanded	\$0.00	\$26.60	\$53.20	\$79.80	\$106.40	\$133.00
99204	New Pt Level IV - Detailed	\$0.00	\$39.00	\$78.00	\$117.00	\$156.00	\$195.00
99205	New Pt Level V - Comprehensive	\$0.00	\$49.00	\$98.00	\$147.00	\$196.00	\$245.00
99211	Est Pt Level I - Minimal	\$0.00	\$7.00	\$14.00	\$21.00	\$28.00	\$35.00
99212	Est Pt Level II - Problem Focus	\$0.00	\$11.40	\$22.80	\$34.20	\$45.60	\$57.00
99213	Est Pt Level III - Expanded	\$0.00	\$15.80	\$31.60	\$47.40	\$63.20	\$79.00
99214	Est Pt Level IV - Detailed	\$0.00	\$24.60	\$49.20	\$73.80	\$98.40	\$123.00
99215	Est Pt Level V - Comprehensive	\$0.00	\$36.60	\$73.20	\$109.80	\$146.40	\$183.00
99361	Medical Conference (30 min)	\$0.00	\$14.60	\$29.20	\$43.80	\$58.40	\$73.00
99362	Medical Conference (60 min)	\$0.00	\$24.00	\$48.00	\$72.00	\$96.00	\$120.00
99381	Well Exam <1	\$0.00	\$24.00	\$48.00	\$72.00	\$96.00	\$120.00
99382	1-4 Yr Exam	\$0.00	\$26.00	\$52.00	\$78.00	\$104.00	\$130.00

<b>CPT / Medicaid Codes</b>	<b>CPT / Medicaid Description</b>	<b>0%</b>	<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>
99383	5-11 Yr Exam	\$0.00	\$30.80	\$61.60	\$92.40	\$123.20	\$154.00
99384	12-17 Yr Exam	\$0.00	\$33.80	\$67.60	\$101.40	\$135.20	\$169.00
99385	18-39 Year Exam	\$0.00	\$33.40	\$66.80	\$100.20	\$133.60	\$167.00
99386	40 - 64 Year Exam	\$0.00	\$39.80	\$79.60	\$119.40	\$159.20	\$199.00
99387	Over 65 Year Exam	\$0.00	\$43.00	\$86.00	\$129.00	\$172.00	\$215.00
99391	Well Exam <1	\$0.00	\$18.20	\$36.40	\$54.60	\$72.80	\$91.00
99392	1-4 Yr Exam	\$0.00	\$20.20	\$40.40	\$60.60	\$80.80	\$101.00
99393	5-11 Yr Exam	\$0.00	\$25.20	\$50.40	\$75.60	\$100.80	\$126.00
99394	12-17 Yr Exam	\$0.00	\$29.20	\$58.40	\$87.60	\$116.80	\$146.00
99395	18-39 Yr Exam	\$0.00	\$28.40	\$56.80	\$85.20	\$113.60	\$142.00
99396	40 - 64 Year Exam	\$0.00	\$31.60	\$63.20	\$94.80	\$126.40	\$158.00
99397	Over 65 Year Exam	\$0.00	\$35.00	\$70.00	\$105.00	\$140.00	\$175.00
99401	Prev Medical Counseling - 15 Min	\$0.00	\$8.00	\$16.00	\$24.00	\$32.00	\$40.00
99402	Prev Medical Counseling - 30 Min	\$0.00	\$15.20	\$30.40	\$45.60	\$60.80	\$76.00
99403	Prev Medical Counseling- 45 Min	\$0.00	\$22.60	\$45.20	\$67.80	\$90.40	\$113.00
99404	Prev Medical Counseling- 60 Min	\$0.00	\$28.80	\$57.60	\$86.40	\$115.20	\$144.00
99411	Group Counseling - 30 Min	\$0.00	\$7.80	\$15.60	\$23.40	\$31.20	\$39.00
99412	Group Counseling - 60 Min	\$0.00	\$13.60	\$27.20	\$40.80	\$54.40	\$68.00
99420	Admin & Interpretation Health Risk	\$0.00	\$17.60	\$35.20	\$52.80	\$70.40	\$88.00
j1055	DepoProvera Injection	\$0.00	\$10.80	\$21.60	\$32.40	\$43.20	\$54.00
	<b>Laboratory Services</b>						
36415	Venipuncture	\$0.00	\$2.80	\$5.60	\$8.40	\$11.20	\$14.00
36416	Fingerstick	\$0.00	\$2.80	\$5.60	\$8.40	\$11.20	\$14.00
80051	Electrolite Panel	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
80053	Comp Metabolic Panel	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
80061	Lipid Panel	\$0.00	\$5.00	\$10.00	\$15.00	\$20.00	\$25.00
80069	Renal Panel	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
80076	Hepatic Panel	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
80188	Mysoline/Primidone Level	\$0.00	\$9.60	\$19.20	\$28.80	\$38.40	\$48.00
81001	Urinalysis, auto, w/microscopic	\$0.00	\$2.40	\$4.80	\$7.20	\$9.60	\$12.00
81003	Urinalysis, auto, without microscopic	\$0.00	\$1.60	\$3.20	\$4.80	\$6.40	\$8.00
81025	Urine Pregnancy Test	\$0.00	\$2.20	\$4.40	\$6.60	\$8.80	\$11.00
82040	Albumin	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
82120	Amines- Wet Mount	\$0.00	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00
82247	Bilirubin, Total	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
82248	Bilirubin, Direct	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
82270	Test Feces Blood (Occult Bld)	\$0.00	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00
82465	Assay Serum Cholesterol	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
82550	CK	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
82553	MB	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
82565	Assay Creatinine	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
82728	Ferritin	\$0.00	\$5.00	\$10.00	\$15.00	\$20.00	\$25.00
82746	Folic Acid	\$0.00	\$5.00	\$10.00	\$15.00	\$20.00	\$25.00
82947	Glucose, quantitative	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
82948	Glucose, quantitative,blood, reagent strip	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
83036	Hemoglobin A1C	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
83540	Iron	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
83550	TIBC (Iron Binding Cap)	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
83615	Lactate (LD) (LDH) Enzyme	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00

<b>CPT / Medicaid Codes</b>	<b>CPT / Medicaid Description</b>	<b>0%</b>	<b>20%</b>	<b>40%</b>	<b>60%</b>	<b>80%</b>	<b>100%</b>
83718	Lipoprotein (HDL)	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84075	Assay Alaline Phosphate	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84152	PSA	\$0.00	\$7.00	\$14.00	\$21.00	\$28.00	\$35.00
84175	Protein, Total	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84436	T4, Total	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84439	T4, Free	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
84443	TSH	\$0.00	\$6.00	\$12.00	\$18.00	\$24.00	\$30.00
84450	SGOT/AST	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84460	SGPT/ALT	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84478	Triglycerides	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84480	T3, Total	\$0.00	\$5.00	\$10.00	\$15.00	\$20.00	\$25.00
84520	BUN	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
84703	Serum Pregnancy Test	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
85018	Hemoglobin	\$0.00	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00
85025	Complete CBC w/Diff	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
85027	Coulter Hematology Profile	\$0.00	\$2.60	\$5.20	\$7.80	\$10.40	\$13.00
85651	RBC SED Rate, non-auto	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
86308	Mono Test	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
86592	Serology, qualitative (trust)	\$0.00	\$3.60	\$7.20	\$10.80	\$14.40	\$18.00
86593	Serology, quantitative (trust)	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
86803	Hepatitis C Antibody	\$0.00	\$5.00	\$10.00	\$15.00	\$20.00	\$25.00
87070	Culture (including throat, GC, wound)	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
87081	Culture, GC, screening only (FP)	\$0.00	\$4.00	\$8.00	\$12.00	\$16.00	\$20.00
87086	Urine Culture, plating and colony count	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
87184	Susceptibility Studies	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
87205	Gram Stain (STD and wound)	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
87210	Wet Smear	\$0.00	\$3.00	\$6.00	\$9.00	\$12.00	\$15.00
87880	Strep A Kit	\$0.00	\$8.00	\$16.00	\$24.00	\$32.00	\$40.00
88175 90	Pap Smear	\$0.00	\$2.47	\$4.93	\$7.40	\$9.86	\$12.33
99000	Handling Fee	\$0.00	\$3.60	\$7.20	\$10.80	\$14.40	\$18.00

**NEW HANOVER COUNTY HEALTH  
BAD DEBT WRITE OFF POLICY**

After all procedures have been followed as previously described in the New Hanover County Health Department fee policy, the bad debt write off procedures will be as followed:

Bad debts will be written off as un-collectable, 13 months following the date of the last visit except when:

1. There has been no intervening charge visit within 13 months and the patient still wishes to remain an active patient. Future services may be denied if effort for payment is not made.
2. Small amounts are being paid toward the bill.

An itemized list of un-collectable outstanding patient balances will be prepared at the end of the fiscal year for the Health Director's review. Those approved by the Health Director and the Board of Health will be written off. The Accounts Receivable system shall indicate the recording of the bill as un-collectable by adjusting the patient balance to zero. Evidence shall be on file to document required billings.

A self-pay patient (categorized as a 60% or greater on the sliding fee scale) with a previous bad debt write off will not be allowed to charge services unless a payment is made toward their previous balance and other payment arrangements are agreed upon. A self-pay patient, categorized as 40% or below on the sliding fee scale, will not be denied services but their account will be reactivated. Exception to this rule is Family Planning. Payment arrangements will be made for all outstanding bad debt and any current unpaid balances for Family Planning services.

If a patient returns to the health department after a bad debt has been determined un-collectable their bad debt write off shall be reactivated and the billing process resumes. The patient's account balance will be reinstated at the full amount of the write off.

A patient should never be informed that a debt has been written off.

All eligible bad debts will be referred to the New Hanover County Legal Office for possible collection through their internal collection process, Small Claims Court or through the North Carolina Local Government Debt Set-off Clearinghouse. Upon collection, the patient's account will be re-activated.

A copy of the Bad Debt Write-off for the fiscal year will be sent to the New Hanover County Finance Office.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Health Director

\_\_\_\_\_  
Chairman, Board of Health

Name:	<b>New Hanover County Health Department</b> <b>2029 South 17<sup>th</sup> Street</b> <b>Wilmington, North Carolina 28401</b> <b>Phone: (910) 798-6500</b> <b>Fax Medical Records (910) 772-7805</b>
DOB:	
SS#	

## Socio-Economic Income Statement

**Circle Correct Answers:**

<b>Resident of North Carolina</b>	<b>Yes</b>	<b>No</b>
<b>Medicaid Eligible</b>	<b>Yes</b>	<b>No</b>
<b>Insurance</b>	<b>Yes</b>	<b>No</b>
<b>Self-pay</b>	<b>Yes</b>	<b>No</b>
<b>No-pay</b>	<b>Yes</b>	<b>No</b>

\_\_\_\_\_ **Gross annual income of economic unit**  
 \_\_\_\_\_ **Total number in household supported by income above.**

**Sliding Fee Scale Percentage:**

**Family Planning (101 - 250% of Poverty Level):** \_\_\_\_\_ %  
**Mobile Dental Unit Services (101 - 250% of Poverty Level)** \_\_\_\_\_ %  
**Other Sliding Fee Services (101 - 350% of Poverty Level):** \_\_\_\_\_ %

Gross income is defined as salary, wages, overtime pay, earnings from self-employment, investment income (stocks, bonds, savings account interest, rentals, etc.), public assistance monies, unemployment compensation, alimony, child support, military allotments, Social Security benefits, Veteran=s Administration benefits, retirement and pension, Worker=s Compensation, regular contributions from individuals not living in the household, Supplementary Security Income (SSI) benefits, and prize winnings.

Economic unit includes persons living in the household, related or non-related, who share their production of income and consumption of goods.

Verification of income is required as noted in the New Hanover County Health Department (NHCHD) Fee Policy. Patients who do not provide proof of income at time of registration will be charged 100% of our current fees for services provided with the exception of Family Planning patients in the Women’s Preventive Health Program. Patient’s declaration of income shall be accepted for Family Planning patients receiving services in the Women’s Preventive Health Program. Patients will have 10 business days to return to the NHCHD with proof of income in order for the sliding fee scale to apply. If proof of income has not been provided within the 10 business day period, charges will remain at the full 100% of our current fees. Patients who do not prefer to provide proof of income will be charged 100% of our current fees.

Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief, this income statement is true and correct. I understand that the information may be checked by a state reviewer, and I agree to provide financial records required to carry out this review. I also understand that my employer may be asked to verify information concerning my income and/or income may be verified via the Employment Security Commission (ESC) database.

- I prefer not to provide NHCHD with proof of income; therefore, I understand that I am fully obligated for payment of services provided.
- Declaration of income – Family Planning/Women’s Preventive Health.
- Proof of income has been provided. Documentation provided by: (circle) Patient ESC Database
- Proof of income will be provided within 10 business days of signature date below. I understand if proof of income is not provided within the 10 business day period, charges will remain at 100% of current charges.

I, the undersigned, verify the above information is true to the best of my knowledge and I understand payment is expected at the time of service for all services rendered.

\_\_\_\_\_/\_\_\_\_\_  
 Signature of Patient/Parent/Authorized Representative/Date Relationship of Authorized Representative

\_\_\_\_\_/\_\_\_\_\_  
 Signature of Witness/Date

Proof of Income Received: \_\_\_\_\_ Received within 10 Business Days: Yes No  
 Gross Annual Income of Economic Unit: \_\_\_\_\_ Total Number in Economic Unit: \_\_\_\_\_  
 FP/Mobile Dental Unit Sliding Fee Scale % \_\_\_\_\_ Other Sliding Fee Scale % \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
 Signature of Parent/Guardian/Authorized Representative/Date Signature of Witness/Date

Revised 08-14-06

New Hanover County Health Department  
**FINANCIAL AGREEMENT / PAYMENT PLAN**

**POLICY STATEMENT**

Payment is expected at the time of service for all services rendered. Partial payment is accepted for services with the exception of private stock vaccines. A financial agreement and payment plan will be established for all patients with a remaining balance.

Patients whose accounts exceed \$50.00 and have made no "good faith" effort to pay will be subject of service restriction as allowed by law.

---

**PAYMENT PLAN**

Previous Balance		_____
New Charges	+	_____
Total		_____
Today's Payment	--	_____
Current Balance		_____

Patient will agree to pay \$\_\_\_\_\_ on a weekly / bi-weekly / monthly basis until the current balance noted above is paid in full.  
(circle)

In the event a patient returns for additional services for which a partial payment is made, a new financial agreement will be required.

---

I have read the payment plan as noted above and agree to comply with the specified terms.

Signature\_\_\_\_\_ Date\_\_\_\_\_  
(Patient)

Signature\_\_\_\_\_ Date\_\_\_\_\_  
(Health Dept Representative)

3/21/06

# Authorization and Assignment of Benefits Form

Patient Social Security # \_\_\_\_\_

LAST Name			
FIRST Name		Middle / Maiden	
Medicaid ID#		Medicaid Name	
Medicare ID#		Medicare Name	
Subscriber's Name			
Insurance Company Name & Address		Insurance Company Number	
Secondary Ins Company Name & Address		Secondary Ins Company Number	

## AUTHORIZE

I request the payment of authorized Medicaid / Medicare / 3<sup>rd</sup> Party Payor benefits be made on my behalf to New Hanover County Health Department (NHCHD) for any services provided. I authorize any holder of medical information (to include HIV information / Substance Use / Mental health and Social Data) about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

I understand that my signature will serve as legal "signature on file" for purposes of filing my insurance claims and payment of benefits to the NHCHD for services rendered.

I understand that my insurance company will send an Explanation of Benefits (EOB) to the address provided on the HCFA form when any claims are processed for services provided.

I agree to repay the NHCHD any money I received from insurance for services that the Health Department provided for me. I further agree that failure to repay assigned insurance benefits to the NHCHD is a reason for denial or restriction of future services until such amounts have been repaid.

Signature of Patient/Parent/Authorized Representative	Date	Relationship of Authorized Representative
Representative's Address		
Reason Patient is unable to sign		
Signature of Witness		Date

## DO NOT AUTHORIZE

I do not authorize billing of my insurance company for services provided or release of information for services provided (to include HIV information / Substance Use / Mental Health and Social Data) due to breach of confidentiality with notification of claims processing on the Explanations of Benefits.

Signature of Patient/Parent/Authorized Representative	Date	Relationship of Authorized Representative
Representative's Address		
Reason Patient is unable to sign		
Signature of Witness		Date

1. Last Name First Name MI

**PERSONAL DATA SHEET**

2. Patient Number \_\_\_\_\_

3. Date of Birth \_\_\_\_\_  
Month Day Year

4. Race:  1. White  2. Black/African American  
 3. American Indian/Alaska Native  4. Asian  
 5. Native Hawaiian/Other Pacific Islander  5. Other  
 Ethnicity: Hispanic/Latino Origin?  Yes  No

5. Gender  1. Male  2. Female

6. County of Residence \_\_\_\_\_

Social Security No. \_\_\_\_\_

Medicaid No. \_\_\_\_\_

Medicare No. \_\_\_\_\_

Health Insurance Coverage \_\_\_\_\_

Maiden & Other Names \_\_\_\_\_

Self Pay % \_\_\_\_\_

Physician/Primary Care Provider \_\_\_\_\_

Notice of Privacy Practices given by \_\_\_\_\_ date \_\_\_\_\_

Name Used by Third Party Payor \_\_\_\_\_

Date	Mail Y/No	Address	Grade	Mar. Stat.	Contact Phone Number	Work/School Name/Phone	Wk/School Hrs
		Present Address					
		Address Change					
		Address Change					
		Address Change					
		Address Change					
		Directions					
		English Speaking <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____			Interpreter needed <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Migrant Farm Worker <input type="checkbox"/> Yes <input type="checkbox"/> No Refugee <input type="checkbox"/> Yes <input type="checkbox"/> No			COUNTRY OF ORIGIN: _____		
		Seasonal Farm Worker <input type="checkbox"/> Yes <input type="checkbox"/> No Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No					

Confidential Contact \_\_\_\_\_  
Name Relationship Address Phone

Emergency Contact \_\_\_\_\_  
Name Relationship Address Phone

Persons living in home	DOB or Age	Gender	Relationship to patient, school and grade, away, deceased (date)

DHHS 2800 (Revised 12/04)  
PHNPD (Review 12/07)

Patient Name # of DOB  
 or  
 Adult Patient Label Here

### SOURCES OF INCOME

Date	Name of Family Members with an Income	List all Employers or Sources of Income	Dates of Employment From To	Wages	AFDC SSI	Retirement	Other	Total Income Before Taxes

**THE ABOVE INFORMATION I HAVE GIVEN IS CORRECT. I UNDERSTAND THE HEALTH DEPARTMENT HAS THE RIGHT TO CHECK THIS INFORMATION.**

Interviewer's signature

Patient's signature

Interviewer's signature		Patient's signature		Family Size	Total Income Before Taxes
(Signature)	(Date)	(Signature)	(Date)		
(Signature)	(Date)	(Signature)	(Date)		
(Signature)	(Date)	(Signature)	(Date)		
(Signature)	(Date)	(Signature)	(Date)		
(Signature)	(Date)	(Signature)	(Date)		
(Signature)	(Date)	(Signature)	(Date)		

### ENVIRONMENT

Date	Food Stamps	Free Lunch Prog.	WIC	Working Refrig. Stove	Power On	Heat	Water System Public Other	Indocr Plumb.	Review Dates	Review Dates

DHHS 2300  
 PHNPD (Review 12/07)

