Self Pay Form

Patient Name: _____ ENC#: _____ Date: ____/____/_____

☐ Service	Services Performed	Price
☐ Urgent Care Visit		$125.00
☐ Point of Care (POC) Testing		$ 50.00
☐ X-Ray		$ 50.00
☐ EKG		$ 50.00
☐ Procedure*		$ 75.00
☐ Immunization ☐ TDAP		$ 75.00 (per vaccine)
☐ Immunization ☐ TD		$ 50.00 (per vaccine)
☐ PPD Plant (including read)		$ 30.00
☐ Orthopedic Supplies x _____		$ 20.00 (per supply)
☐ Wound Check (only if previously assessed by MCUC)		$ 75.00
☐ Suture Removal (only if placed by MCUC)		N/C
☐ Other: _____		$_____
Total Due:		$_____

*Procedure:

- Control of nasal hemorrhage
- Nebulizer Treatment
- I + D
- Ear Flushing
- Debridement of nails
- Ortho glass/splint application
- Laceration repair
- Dislocation reduction
- Removal of foreign body
- Wound debridement
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