CENTRAL UTAH PUBLIC HEALTH DEPARTMENT-SPANISH CLIENT ENCOUNTER FORM

Fecha de la Visita _____/_____ /_____

Paciente Nombre _____ Padro/Guardian _____

Fecha de Nacimento _____/_____/_____ Edad _____ Sexo M F Numero de telefono (_____) _____-_____

Direccion_____ Ciudad,Estado Codigo Postal _____

Nombre de Seguro_____ Nombre del Asegurado_____

Relacion: _____ Poliza de seguro #: _____ Numero de su grupo#_____

Certifico que la informacion que he dad es verdadera y corrects. Authorizo y doy consentinento para la s pruebha s medica s y tratemiento de emergencia que prescriban los proveedores de salud del department de salud de la central de Utah. Yo libero al department de salud de la parte central De Utah y a susaliados de todos los reclamos que puedan surgir debido a este tratamiento. Yo authorize al Departmento de Salud de la parte Central de Utah a que cobren a Medicaid, medicare o segure.

Entiendo que si mi proveedor de seguros no cubre los costo de este servicio, Yo sere responsible del pago de estos servicios.

Signature _____ Date _____ Relationship to Patient _____

**********FOR OFFICE USE ONLY**********

Poverty Level: ↓100% 101%-200% ↑200%

FAMILY PLANNING			AMOUNT
81025	Z32.00	Preg Test Urine + -	
99204	Z30.02	Initial	$15
99215	Z30.02	Annual	$15
99401	Z30.02	Est Brief	
85014	Z30.02	HCT	
BP/W	Z30.02		

FP SUPPLIES REC'D			AMOUNT
A4267	Z30.09	Condoms	
J1050	Z30.09	Depo Inject	$20
S4993	Z30.09	Oral Contraceptives	$5.00
J7303	Z30.09	NuvaRing	$20
J7297	Z30.09	Liletta IUD	$50
J7304	Z30.09	Patch	$20

CHEC/MEDICAID		
99381	Z00.129	New Child <1
99391	Z00.129	Est Child <1
99382	Z00.129	New Child 1-4
99392	Z00.129	Est Child 1-4
99383	Z00.129	New Child 5-11
99393	Z00.129	Est Child 5-11

PRENATAL-BABY YOUR BABY			AMOUNT
T1017	Z34.00	Telephone Visit	Units_____
T1017	Z34.00	Initial Visit	Units_____
T1017	Z34.00	Home Visit t	Units_____
81025	Z32.01	Pregnancy Test	

Risk Reduction Health			AMOUNT
83718	Z13.220	Cholesterol Test	$20
BP	Z13.220	Blood Pressure Scrn	
543		Education	
G9016	F17.200	Smoking Cessation	$25
552		Smoking Cessation Grp	
89016		Tobacco Handlers Class	$15

LABORATORY			AMOUNT
83655	Z13.88	Lead Test	$20
81025	Z32.00	Pregnancy Test (01B) + -	$10
81002	Z13.89	Urinalysis	$10
83036	Z13.0	Hemoglobin	$10
BP/W		Blood Press/Weight	
82948	Z13.1	Glucose	$10
83036	Z13.1	A1C	$18
99201	A56.2	Std-test Confi <25 C/G	$25
99201	A64	Std-test Confi <25 H	$25
99201	A56.2	Std-test Confi >25 C/G	$45
99201	A64	Std Test Confi >25 H	$45
HEP C	Z11.59	Hepatitis C Test	$20

(Do Not Bill Insurance-Self-Pay Only)

EARLY CHILD MEDICAID/TMC			AMOUNT
T1023	Z71.89	TCM-Initial 0-1	
T1017	Z71.89	TCM-follow-up	Units_____
S9453	Z87.891	Smoking Cess. Face	
S9453	Z87.891	Smoking Telephone	

BRIGHT BEGINNINGS			
99341	20 min.	99344	60 min,
99342	30 min.	99345	75 min.
99343	45 min.		

WELL CHILD			AMOUNT
99381	Z00.129	New Child <1	$60
99391	Z00.129	Est Child <1	$50
99382	Z00.129	New Child 1-4	$65
99392	Z00.129	Est Child 1-4	$55
99383	Z00.129	New Child 5-11	$65
99393	Z00.129	Est Child 5-11	$55

HOME BOUND	
869	Home Visit
601	HIPPA

North Sanpete		South Sanpete
Juab	Wayne Piute	Sevier
East Millard		West Millard

899 No Services

Allergies: _____

_____

Comments: _____

_____

Nurse/Provider: _____

PAYMENT SECTION

Total Charge: _____

Amount Received: _____

Total Owing: _____

Receipt #: _____

CASH	CHECK	CREDIT CARD
MEDICAID	MEDICARE	PCN
CHIP	INSURANCE	CONTRACT

BILL ORGANIZATION: _____

ORG. ADDRESS: _____

_____

Employee Signature:

PAYMENT: _____ SCANNED: _____

BILLING: _____