MILLENNIAL MEDICAL CLINIC

Price Sheet | 2025

Name: _____ DOB: _____ Self-Pay / Insurance

New Patient

CODE	DESCRIPTION	COST
99381	New Pt, Infant	165.00
99382	New Pt, 1 - 4 Years	170.00
99383	New Pt, 5 - 11 Years	175.00
99384	New Pt, 12 - 17 Years	185.00
99385	New Pt, 18 - 39 Years	195.00
99386	New Pt, 40 - 64 Years	200.00
99387	New Pt, 65 + Years	205.00
99202	New Pt, Expanded Visit	109.00
99203	New Pt, Detailed Visit	169.00
99204	New Pt, Comprehensive Visit	250.00
99205	New Pt, Comprehensive Visit	330.00

Medications

CODE	DESCRIPTION	COST
J8540	Dexamethasone Oral	10.00
J1100	Dexamethasone Injection	10.00
J0696	Rocephin	10.00
J0171	Epinephrine up to 1 mL	15.00
96372	Admin of Med / Injection	20.00
J1885	Toradol Injection	10.00
J3420	B12 Injection	12.00

Est. Patient

CODE	DESCRIPTION	COST
99391	Est. Pt, Infant	145.00
99392	Est. Pt, 1 - 4 Years	155.00
99393	Est. Pt, 5 - 11 Years	157.00
99394	Est. Pt, 12 - 17 Years	170.00
99395	Est. Pt, 18 - 39 Years	175.00
99396	Est. Pt, 40 - 64 Years	185.00
99397	Est. Pt, 65 + Years	190.00
99213	Est. Pt, Expanded Visit	135.00
99214	Est. Pt, Detailed Visit	190.00
99215	Est. Pt, Comprehensive Visit	270.00
99211	Est. Pt, Nurse Visit	35.00
99212	Est. Pt, Focused Visit	85.00
99050	Est. Pt, After-Hours Add-On	15.00

Other Add-On

CODE	DESCRIPTION	COST
99173	Vision Screening	10.00
99177	Spot Vision	20.00
92552	Hearing Screening	25.00
99401	Counseling Well, +15 Min.	35.00
99402	Counseling Well, +30 Min.	65.00
S9441	Asthma Education	20.00

In-House Lab 1/2

CODE	DESCRIPTION	COST
36416	Finger/Heel Stick	10.00
36415	Venipuncture	15.00
85018	Hemoglobin	10.00
82270	Fecal Occult	10.00
82947	Glucose In-House	20.00
81025	Pregnancy Test	20.00
99000	Specimen Handling	5.00

In-House Lab 2/2

CODE	DESCRIPTION	COST
87880	Rapid Strep	35.00
81003	Urinalysis	10.00
87804	Flu A & B x Covid Rapid	40.00
87428	Covid x Flu A & B In-House	80.00
87807	RSV Rapid In-House	30.00
80305	Urine Drug Screen	20.00

INSURANCE / SELF PAY VISIT TOTAL	
COPAY	
20% TOWARDS DEDUCTIBLE	
SELF-PAY	

COPAY AMOUNT PAID:

_____

ADDITIONAL PAYMENT:

_____

Patient Name: _____ Date: _____

Patient/Guarantor Signature: _____

Separate Services - (Not Covered) 1/2

PAID?	DESCRIPTION	COST
	FMLA Paperwork (rec/eCW)	45.00
	Letters (rec/eCW)	10.00
	Forms (rec/eCW)	15-35

Separate Services 2/2

PAID?	DESCRIPTION	COST
	Childcare Physical (sq)	35.00
	D.O.T. Physical (sq)	80.00
	Sports Physical (sq)	35.00
	Ear Piercing - Plastic (sq)	60.00
	Ear Piercing - Titanium (sq)	80.00
	Ear Numbing Gel (sq)	5.00