

# IMMIGRATION PHYSICAL

PHYSICAL- \$240.00 W/ PPD.

NO INSURANCE ACCEPTED

*as of  
March 2014*

# DH LAB SELF PAY RATES

(MOST COMMON LABS, SEE DH LAB SERVICE PACKET FOR COMPLETE LIST)

MEASLES	\$20.37
MUMPS	\$20.63
RUBELLA	\$22.76
VARICELLA	\$20.37
HEP B SURFACE ANTIBODY	\$16.97
LIPID	\$21.18
BMP	\$13.37
CMP	\$16.71

As of March 2014

**LAB TESTS AND FEE'S**

CPT	DESCRIPTION	DOCTOR'S EXPRESS FEE
86900	ABO TYPE	5.00
86901	RH TYPE	5.00
86880	COOMBS DIR EA ANTISERA	9.00
80051	ELECTROLYTE PANEL	12.00
80076	HEPATIC PROFILE	13.00
80061	LIPID PANEL	22.00
80048	METABOLIC PANEL	14.00
80053	COMPREHENSIVE METABOLIC PANEL	17.00
80069	RENAL FUNCTION PANEL	14.00
82977	GGT	12.00
82947	GLUCOSE QUANT	7.00
82945	GLUCOSE URINE/FLUID	7.00
83718	HDL CHOLESTEROL	13.00
83540	IRON	11.00
83605	LACTATE	17.00
83615	LD/LDH	10.00
83690	LIPASE	11.00
80178	LITHIUM	11.00
83735	MAGNESIUM SERUM/URINE	11.00
83935	OSMOLALITY URINE	11.00
83930	OSMOLALITY SERUM	11.00
80184	PHENOBARBITAL	19.00
80185	PHENYTOIN	21.00
84075	ALK. PHOSPHATASE	9.00
84100	PHOSPHORUS	8.00
84105	PHOSPHORUS URINE	9.00
84132	POTASSIUM SERUM	8.00
84133	POTASSIUM URINE/FLUID	7.00
84155	PROTEIN TOTAL SERUM	6.00
84157	PROTEIN TOTAL FLUID	6.00
84156	PROTEIN TOTAL URINE	6.00
80196	SALICYLATE	12.00
84295	SODIUM BLOOD	7.00
84300	SODIUM URINE	8.00
80198	THEOPHYLLINE	23.00
87340	HEP B SURFACE ANTIGEN	17.00
86706	HEP B SURFACE ANTIBODY	17.00
86705	HEP B CORE IGM AB	19.00
86704	HEP B CORE AB TOTAL	20.00
86709	HEP A AB IGM	18.00
86708	HEP A AB TOTAL	20.00
86703	HIV 1/2/ANTIBODY	22.00

as of MARCH 2024

86803	HEP C ANTIBODY	23.00
84478	TRIGLYCERIDES	10.00
84520	BUN QUANT	7.00
83721	DIRECT LDL	16.00
84540	UREA NITROGEN URINE	8.00
84550	URIC ACID BLOOD	8.00
84560	URIC ACID FLUID/URINE	8.00
80164	VALPORIC ACID	22.00
80202	VANCOMYCIN	22.00
82306	VITAMIN D 25 OH	47.00
84484	TNT QUANTITATIVE	16.00
82553	CK MB MASS	19.00
86304	CA 125	33.00
84481	FREE T3	27.00
86376	ANTI TPO	20.00
83525	INSULIN	19.00
84432	THYROGLOBULIN	26.00
82533	CORTISOL	26.00
86800	ANTI THYROGLOBULIN AB	23.00
83880	B-TYPE NATRIUREPTIC PEPTIDE	54.00
82105	ALPHA FETOPROTEIN	27.00
86300	CA 15 3	33.00
82785	TOTAL IGE	27.00
86003	PER ALLERGEN	9.00
82668	ERYTHROPOIETIN	30.00
82043	MICROALBUMIN, URINE	10.00
86140	C-REACTIVE PROTEIN	9.00
86141	HS CRP	21.00
86431	RHEUMATOID FACTOR	9.00
86160	COMPLEMENT C3	19.00
86160	COMPLEMENT C4	19.00
84134	PREALBUMIN	24.00
86301	CA 19-9	33.00
86666	H G E AB (EHRlichIA AB)	17.00
86147	ANTICARDIOLIPIN ANTIBODY IGG	41.00
86147	ANTICARDIOLIPIN ANTIBODY IGM	41.00
82232	BETA 2 MICROGLOBULIN	26.00
86618	C 6 PEPTIDE	27.00
86644	CMV IGG	23.00
86225	DNA DS	22.00
83036	GLYCOHEMOGLOBIN	16.00
86618	LYME SEROLOGY	27.00
86765	MEASLES ANTIBODY	21.00
86735	MUMPS	21.00
86762	RUBELLA ANTIBODY	23.00
86787	VARICELLA ANTIBODY	21.00



# Doctors Express®

## Urgent Care When You Need It

AS of March 2014

Patient Label Here

### Pricing for Vaccinations

Check box if vaccination was received during this office visit

Received	Vaccine (ICD-9 Code)	CPT Code	Fee*
<input type="checkbox"/>	Travel Consultation Fee (v65.8)	99401 If Self Pay Co-Pay applies if billing insurance	\$ 75.00
<input type="checkbox"/>	Tdap (v06.1)	90715	\$ 55.00
<input type="checkbox"/>	Tetanus/diphtheria (Td) (v06.5)	90714	\$ 50.00
<input type="checkbox"/>	Rabies (V01.5 and V04.5) (3 needed) Day 0, 7, 21 or 28 DOSE 1: _____ DOSE 2 DUE: _____ DOSE 3 DUE: _____	90675	\$ 325.00 each
<input type="checkbox"/>	MMR (v06.4) (1 or 2 needed)	90707	\$ 100.00 each
<input type="checkbox"/>	Hepatitis A (v05.3) (2 needed) Day 0, 180 DOSE 1: _____ DOSE 2 DUE: _____	90632 Adult 90633 Pediatric	\$ 100.00 each
<input type="checkbox"/>	GamaSTAN (v05.3) (up to 2 ml - one dose)	J1460 per 1 ml J1560 over 10 ml	\$ NA
<input type="checkbox"/>	Hepatitis B (v05.3) (3 needed) Day 0, 30, 180 DOSE 1: _____ DOSE 2 DUE: _____ DOSE 3 DUE: _____	90746 Adult 90744 Pediatric	\$ 100.00 each
<input type="checkbox"/>	Meningitis (v03.89)	90734 - MENACTRA 90733 - MENOMUNE	\$ 205.00
<input type="checkbox"/>	Typhoid Fever (v03.1)	90691	\$ 115.00
<input type="checkbox"/>	Yellow Fever (v04.4)	90717	\$ 180.00
<input type="checkbox"/>	Polio (v04.0)	90713	\$ 70.00
<input type="checkbox"/>	Varicella (v05.4) (2 needed) Day 0, 4-8 weeks DOSE 1: _____ DOSE 2 DUE: _____	90716	\$ 180.00 each
<input type="checkbox"/>	Japanese Encephalitis (v05.0 and 0620) (3 needed) Day 0, 7, 30	90735 Sub Q 90738 Vaccine IM	\$ NA
<b>TOTAL COST (including office consultation*)</b>			<b>\$ 0.00</b>

\* Fee may vary per center

X

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

2 Main St. Danbury, CT 06810 (203) 826-2140

Monday - Friday: 8AM - 8PM • Saturday: 8AM - 5PM • Sunday: 8AM - 5PM

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