SUMMIT COUNTY PUBLIC HEALTH
CLINIC FEE SCHEDULE[1,2,3]

SERVICE TYPE		FEES EFFECTIVE April 15, 2017
CLINIC SERVICES		
2000F	Blood Pressure	$15.00
82551	Hearing Screening	$25.00
99173	Vision Screening	$25.00
865801	Mantoux (TB Skin Test)	$20.00
865802	Two step Mantoux (TB Skin Test)	$35.00
---	Non-Contractual Professional Consulting Services (hour)	$50.00
---	Court Ordered STD Testing	$95.00
---	Documentation HIV Testing	$20.00
OFFICE VISITS - PHYSICIAN / NURSE PRACTITIONER		
99201	New Patient Office Visit brief	$30.00
99202	New Patient Office Visit limited (10 min)	$45.00
99203	New Patient Office Visit medium (20 min)	$70.00
99204	New Patient Office Visit moderate (30 min)	$100.00
99205	New Patient Office Visit comprehensive-moderate(45min)	$120.00
99206	New Patient Office Visit comprehensive-detailed (60 min)	$110.00
99212	Established Patient Office Visit limited (10 min)	$40.00
99213	Established Patient Office Visit medium (15 min)	$50.00
99214	Established Patient Office Visit moderate (25 min)	$70.00
99215	Established Patient Office Visit high (40 min)	$90.00
OFFICE VISITS - NURSE		
99211	Brief Assessment	$20.00
REFUGEE HEALTH SERVICES		
---	Refugee navigator service for new arrivals as per ODJFS contract	$50.00
---	Examinations and testing as per ODJFS contract	$796.00
I-693	Completion of immunization section of I-693 form	$40.00
RI693	Replacement of I- 693	$25.00

[1]Contractual charges are based on fee schedule in effect at the time contract was signed.

[2]Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs.

[3]Sexually Transmitted Disease (STD) Testing and Treatment are provided free of charge to patients under the age of

SUMMIT COUNTY PUBLIC HEALTH
IMMUNIZATION FEE SCHEDULE[1,2,5]

SERVICE TYPE		FEES EFFECTIVE April 15, 2017
VACCINE		
Vaccines marked with the VFC symbol are available to VFC eligible children at no cost. See VFC Eligibility Criteria below[3]. Vaccine administration fees still apply.		
90472 90473 90474 G0008 G0009	Vaccine Administration Fee (per vaccine)	$21.00
90748	Comvax Vaccine - HIB/Hep B (Pediatric) VFC	$39.00
90649	Gardasil VFC	$199.00
90651	Gardasil 9	$244.00
90632	Hepatitis A Vaccine (Adult)	$54.00
90633	Hepatitis A Vaccine (Pediatric) VFC	$64.00
90746	Hepatitis B Vaccine (Adult)	$74.00
90744	Hepatitis B Vaccine (Pediatric) VFC	$24.00
90636	Hepatitis A/B Combined Vaccine	$104.00
90647 90648	HIB Vaccine VFC	$29.00
90672 90686 90687	Quadrivalent Influenza Vaccine (includes vaccine administration fee)[4] VFC	$45.00
90734	Meningococcal Conjugate Menactra VFC	$134.00
90733	Meningococcal Polysaccharide Menomune VFC	$184.00
90620 90621	Meningococcal Group B	$204.00
90707	MMR Vaccine VFC	$79.00
90732	Pneumococcal Vaccine (Adult)	$104.00
90713	Polio VFC	$29.00
90675	Rabies Vaccine	$349.00
90680	Rotarix VFC	$139.00
90680	Rotateq VFC	$94.00
90714	Td - Decavac or Tenivac VFC	$44.00
90715	Tdap-Adacel or Boostrix VFC	$49.00
90716	Varicella (Chicken Pox) VFC	$139.00
90736	Zostavax	$224.00
90698	Pentacel (Dtap & Polio) (Pediatric) VFC	$89.00
90699 90670	Prevnar (Pediatric) VFC	$219.00
90700	Daptacel (Dtap) (Pediatric) VFC	$34.00
90696	Kinrix (Dtap & Polio ages 4 -6 yrs) (Pediatric) VFC	$64.00
90723	Pediarix (Dtap, Polio, Hep B) (Pediatric) VFC	$89.00
---	Vaccination Site Fee (for off-site clinics)	$50.00
---	Yellow travel book replacement and documentation	$10.00

[1]Contractual charges are based on fee schedule in effect at the time contract was signed.
[2]Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs. Sliding fee scale does not apply to international travel vaccines
[3]VFC (Vaccines for Children Program) Eligibility Criteria- Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccine:

- Medicaid eligible: A child who is eligible for the Medicaid program.
- Uninsured: A child who has no health insurance coverage.
- American Indian or Alaskan Native
- Underinsured: A child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured

[4]Influenza vaccine fees are waived for Board of Health members and Township Association members.

[5]Fees may be waived in response to a communicable disease outbreak.

SUMMIT COUNTY PUBLIC HEALTH
LABORATORY FEE SCHEDULE[1,2,3,4,5]

SERVICE TYPE		FEES EFFECTIVE April 15, 2017
LABORATORY SERVICES		
36415	Specimen Collection Venous	$10.00
36416	Specimen Collection Capillary	$10.00
82962	Glucose Blood Stick	$10.00
LABORATORY TESTS		
87081	Strep Culture	$9.00
87077	Gonorrhea	$12.00
86592	RPR	$7.00
83655	Blood Lead	$18.00
87270	Chlamydia - antigen detection by DFA	$18.00
81025	Pregnancy Test	$10.00
87210	Wet Mount	$7.00
87274	Herpes Type 1	$18.00
87273	Herpes Type 2	$18.00
81002	Urine Dipstick	$4.00
81000	Urine Dipstick/Micro	$5.00
82947	Glucose Serum	$6.00
87340	Hepatitis B (HBSAg)	$14.00
86704	Hepatitis B (HBcAb)	$18.00
86706	Hepatitis B (HBSAb)	$16.00
86803	Hepatitis C	$30.00
86703 87390	HIV	$25.00
85018	Hemoglobin	$4.00
87205	Gram Stain	$7.00
86787	Varicella Titer	$18.00
G0434QW	Urine Drug Screen	$19.42
86480	Quantiferon Gold TB	$86.00
87491	Chlamydia, amplified probe technique (Urine or Swab)	$50.00
87591	Gonorrhoeae, amplified probe technique (Urine or Swab)	$50.00

[1]Contractual charges are based on fee schedule in effect at the time contract was signed.

[2]Other laboratory tests (send outs) are charged according to current fee schedule from laboratory performing the

[3]Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs.

[4]Sexually Transmitted Disease (STD) Testing and Treatment are provided free of charge to patients under the age of

[5]Laboratory tests are only performed on patients receiving other health district services.

COUNSELING FEE SCHEDULE[1]

SERVICE TYPE		FEES EFFECTIVE April 15, 2017
COUNSELING		
H0001	Assessment (hourly)	$96.24
H0006	Case Management (hourly)	$78.17
H0005	Group Counseling (15 min)	$9.52
H0004	Individual Counseling (15 min)	$21.82
H0015	Intensive Outpatient	$136.90
H0022	Intervention (Community Services)	$76.39
H0038	Peer Support	$35.00
A0630	Community-Based Process (Prevention)	$84.96
A0620	Education (Prevention)	$85.04
A0610	Information Dissemination (Prevention)	$85.33
A0780	Urine Drug Screen	$19.42

[1]Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs.

SUMMIT COUNTY PUBLIC HEALTH
DENTAL FEE SCHEDULE[1, *,]**

DENTAL SERVICES		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE April 15, 2017
D0120	Periodic Oral Exam	$35.00
D0140	Limited Oral Exam	$40.00
D0145	Oral Evaluation under age 3	$35.00
D0150	Comprehensive Oral Evaluation over age 3	$55.00
D0210	Intraoral-complete series of x-rays	$90.00
D0220	Periapical X-ray	$20.00
D0230	Additional Periapical X-ray	$15.00
D0240	Intraoral occlusal x-ray	$30.00
D0270	Single Bitewing X-ray	$20.00
D0272	Two Bitewing X-rays	$30.00
D0273	Three Bitewing X-rays	$35.00
D0274	Four Bitewing X-rays	$40.00
D0330	Panoramic Film X-ray	$85.00
D0460	Pulp Vitality Test	$30.00
D0470	Diagnostic casts	$60.00
D1110	Prophylaxis – age 14 through Adult	$55.00
D1120	Prophylaxis – age 13 and Younger	$40.00
D1204	Flouride Treatment only-14 through Adult	$20.00
D1206	Topical application of flouride varnish	$25.00
D1208	Topical application of fluoride-Child	$25.00
D1351	Sealant (per tooth)	$35.00
D1353	Sealant Repair (per tooth)	$35.00
D1510	Space Maintainer-Fixed-Unilateral	$195.00
D1515	Space Maintainer-Fixed-Bilateral	$265.00
D1550	Recementor-Re-Bond Space Maintainer	$45.00
D1555	Removal of Fixed Space Maintainer	$45.00
D2140	Amalgam 1 Surface (primary or permanent)	$90.00
D2150	Amalgam 2 Surfaces (primary or permanent)	$105.00
D2160	Amalgam 3 Surfaces (primary or permanent)	$130.00
D2161	Amalgam 4 or More Surfaces (primary or permanent)	$150.00
D2330	Composite 1 Surface Anterior	$105.00
D2331	Composite 2 Surface Anterior	$150.00
D2332	Composite 3 Surface Anterior	$165.00
D2335	Composite /Incisal Angle/ or 4 surfaces	$190.00
D2391	Resin Composite 1 Surface Posterior	$110.00
D2392	Resin Composite 2 Surface Posterior	$130.00
D2393	Resin Composite 3 Surface Posterior	$150.00
D2394	Resin Composite 4 Surface Posterior	$205.00
D2740	Crown- Porcelain/Ceramic Substrate*	$800.00
D2750	Crown-Porcelain Fused to High Noble Metal*	$820.00
D2751	Crown- Porcelain Fused to Predominantly Base Metal*	$770.00

DENTAL SERVICES (CONTINUED)		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE April 15, 2017
D2752	Crown- Porcelain Fused to Noble Metal*	$770.00
D2790	Crown- Full Cast High Noble Metal*	$800.00
D2791	Crown- Full Cast Predominantly Base Metal*	$745.00
D2792	Crown- Full Cast Noble Metal*	$745.00
D2915	Recement Cast or Prefarbricated Post and Core	$60.00
D2920	Recement or Re-bond Crown	$60.00
D2930	Prefab Stainless Steel Crown-Primary Tooth	$195.00
D2931	Prefab Stainless Steel Crown-Permanent Tooth	$225.00
D2932	Prefabricated Resin Crown	$175.00
D2933	Prefabricated Stainless Steel Crown	$235.00
D2934	Prefabricated Stainless Steel Crown with Resin Window	$200.00
D2940	Dental Sedative Filling	$75.00
D2950	Core Buildup Including Pins When Required	$150.00
D2951	Pin Retention (per tooth)	$30.00
D2952	Post and Core in Addition to Crown- Indirectly Fabricated*	$240.00
D2954	Prefabricated Post and Core in Addition to Crown	$235.00
D2960	Labial veneer (resin laminate) Chairside	$300.00
D2961	Labial veneer (resin laminate) Lab	$500.00
D2962	Labial veneer (porcelain laminate) Lab	$675.00
D2970	Temporary crown (fractured tooth)	$145.00
D2971	Procedures to Construct New Crown Under Denture*	$150.00
D3110	Pulp cap- direct (excluding final restoration)	$45.00
D3120	Pulp cap- indirect (excluding final restoration)	$45.00
D3220	Pulpotomy	$115.00
D3240	Pulpal Therapy -Posterior Primary Tooth	$120.00
D4341	Periodontal Scaling and Root Planing- 4 or more teeth	$140.00
D4342	Periodontal Scaling and Root Planing - 1 to 3 teeth	$115.00
D4355	Full Mouth Debridement	$125.00
D4910	Peridontal Maintainance	$80.00
D5110	Complete Denture - Maxillary*	$925.00
D5120	Complete Denture - Mandibular*	$925.00
D5130	Immediate Denture- Maxillary*	$975.00
D5140	Immediate Denture- Manidibular*	$975.00
D5211	Maxillary Partial Denture -Resin Base*	$650.00
D5212	Mandibular Partial Denture - Resin Base*	$650.00
D5213	Maxillary Partial Denture Cast Metal Framework*	$1,310.00
D5214	Mandibular Partial Denture Cast Metal Framework*	$1,310.00
D5225	Maxillary Partial Denture, Flexible Base*	$1,450.00
D5226	Mandibular Partial Denture, Flexible Base*	$1,450.00
D5410	AdjustComplete Denture - Maxillary	$65.00
D5411	Adjust Complete Denture - Mandibular	$65.00
D5421	Adjust Partial Denture - Maxillary	$65.00
D5422	Adjust Partial Denture - Mandibular	$65.00
D5510	Repair Broken Complete Denture Base	$125.00
D5520	Replace Missing/Broken Denture Teeth (each tooth)	$125.00

DENTAL SERVICES (CONTINUED)		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE April 15, 2017
D5610	Repair Resin Denture Base	$125.00
D5620	Repair Cast Framework	$145.00
D5630	Repair or Replace Broken Clasp	$145.00
D5640	Replace Broken Teeth (per tooth)	$160.00
D5650	Add Tooth to Existing Partial Denture	$160.00
D5660	Add Clasp to Existing Partial Denture	$160.00
D5730	Reline Complete Maxillary Denture (chairside)	$200.00
D5731	Reline Complete Mandibular Denture (chairside)	$200.00
D5740	Reline Partial Maxillary Denture (chairside)	$200.00
D5741	Reline Partial Mandibular Denture (chairside)	$200.00
D5750	Reline Complete Maxillary Denture (lab)	$300.00
D5751	Reline Complete Mandibular Denture (lab)	$300.00
D5760	Reline Partial Maxillary Denture (lab)	$300.00
D5761	Reline Partial Mandibular Denture (lab)	$300.00
D6056	Prefabricated Abutment (Modification and Placement)	$475.00
D6057	Implant Custom Abutment	$565.00
D6058	Abutment Supported Porcelain/Ceramic Crown*	$1,010.00
D6059	Abut Supp Porcelain to Mtl Crown Hi Nob*	$990.00
D6060	Abut Supp Porcelain to Mtl Crown Predom*	$875.00
D6061	Abut Supp Porcelain to Mtl Crown Nob Mtl*	$935.00
D6065	Implant Supported Porcelain/Ceramic Crown*	$1,010.00
D6066	Implant Supported Porcelain Fused to Metal Crown*	$990.00
D6110	Implant Supported Removable Full Denture -Maxillary*	$1,700.00
D6111	Implant Supported Removable Full Denture -Mandible*	$1,700.00
D6112	Implant Supported Removeable Partial -Maxillary*	$2,300.00
D6113	Implant Supported Removeable Partial -Mandible*	$2,300.00
D6240	Pontic- Porcelain Fused to High Noble Metal*	$820.00
D6241	Pontic- Porcelain Fused to Predominantly Base Metal*	$700.00
D6242	Pontic- Porcelain Fused to Noble Metal*	$700.00
D6245	Pontic - Porcelain/Ceramic*	$950.00
D6545	Retainer- Cast Metal for Resin Bonded Fixed Prothsis*	$250.00
D6740	Crown - Porcelain/Ceramic Substrate*	$950.00
D6750	Crown - Porcelain Fused to High Noble Metal*	$820.00
D6751	Crown - Porcelain Fused to Predominantly Base Metal*	$750.00
D6752	Crown - Porcelain Fused to Noble Metal*	$750.00
D6930	Recement or Re-bond Fixed Partial Denture	$50.00
D7111	Extract, Coronal Remnants - Deciduous Tooth	$85.00
D7140	Basic Extraction (per tooth)	$105.00
D7210	Surgical Extraction (per tooth)	$200.00
D7220	Soft Tissue Extraction (per tooth)	$305.00
D7230	Part Bony Impact w/Remov Bone, Tooth Sect	$305.00
D7270	Tooth Reimplantation or Stabilization	$250.00
D7510	Incision & Drainage of Abceses - Intraoral Soft Tissue	$125.00
---	MI Paste Treatment	$20.00
D9110	Palliative (emergency) Tx of Dental Pain	$65.00

DENTAL SERVICES (CONTINUED)		
SERVICE CODE	SERVICE DESCRIPTION	FEES EFFECTIVE April 15, 2017
D9120	Fixed Partial Denture Sectioning	$105.00
D9910	Application of Desensitizing Medicaments	$35.00
D9911	Application of Desensitizing Resin (per tooth)	$75.00
D9940	Occlusal Guard	$400.00
D9941	Fabrication of Athletic Mouthguard	$100.00

[1]Summit County Public Health reserves the right to reduce or waive fees based on sliding fee scale (ability to pay) parameters and/or other state/federal programs. Exclusions and discount limits may apply. See Summit County Public Health Medical and Dental Fee Policy for details.

*Exclusions: The following services will be billed at 60% of actual charges regardless of discount eligibility due to associated lab costs.

-Dentures

-Crowns

-Bridge Work

**The services listed below may not be discounted any lower than the fee to the right regardless of income:

- Extractions non-surgical (per tooth)	$30.00
-Cleaning, exam and diagnostic x-rays (bitewings only)	$50.00
-Emergency walk-in exam, x-ray and extraction	$65.00