Arlington URGENT CARE
3062 Kingsdale Center
Upper Arlington, Ohio 43221

Bexley URGENT CARE
2216 E. Main St.
Bexley, Ohio 43209

Worthington URGENT CARE
2245 W. Dublin-Granville Rd., #101
Columbus, Ohio 43085

Self-Pay Policy

It is the policy of Arlington Urgent Care, Inc., to be forth coming in our self-pay rates. Please refer to the list below for a description of commonly ordered tests for your visit. This is **NOT** an inclusive list and you may be billed for charges not listed below. Please ask your provider for the cost of a procedure or service prior to receiving, you cannot deny the charge once it's given.

Please be prepared to pay $115 prior to being seen. The remaining balance is due at the end of the office visit today.

Charge	Explanation	Cost w/ 30% discount*
Office Visits: All visits will have an associated office visit charge. The level of visit will be determined by the provider and is based on the diagnosis and complexity of care required to treat the condition or illness. Only the provider can determine the treatment and complexity of care needed. We are unable to determine your level of care until you've been examined by a provider and an appropriate treatment plan is determined.		
Level 4 Office Visit (New Patient)	2 of the following: • History, examination, high complexity	$160.00
Level 4 Office Visit (Established Patient)	2 of the following: • History, examination, high complexity	$125.00
Level 3 Office Visit (New Patient)	2 of the following: • History, examination, moderate complexity	$126.00
Level 3 Office Visit (Established Patient)	2 of the following: • History, examination, moderate complexity	$115.00
Testing: The following tests may be ordered and are charged in addition to the office visit.		
EKG	Electrocardiogram: interpretation and report	$ 33.00
Glucose	Blood glucose level	$ 5.00
Influenza	Rapid flu testing	$ 21.00
Mononucleosis	Rapid mono testing	$ 10.00
Pregnancy	Pregnancy testing	$ 12.00
Streptococcus	Rapid strep testing	$ 21.00
Urinalysis	Urinalysis performed in clinic	$ 5.00
Radiology: The following x-rays may be ordered and are charged in addition to the office visit. **Please note x-ray charges are determined based on the number of views needed to adequately diagnosis your injury. Comparison views of the alternate limb may also be needed.*		
Ankle	X-ray ankle (3 view)	$ 40.00
Cervical	X-ray neck (2 view)	$ 64.00
Chest	X-ray chest (2 views)	$ 53.00
Elbow	X-ray elbow	$ 41.00
Foot	X-ray foot	$ 38.00
Hand	X-ray hand	$ 39.00
Knee	X-ray knee (3 views)	$ 45.00
Lower back	X-ray back	$ 45.00
Shoulder	X-ray shoulder	$ 38.00

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Wrist	X-ray wrist	$ 45.00
Procedures: The following procedures may be ordered and are charged in addition to the office visit. *Complexity of repair can only be determined once the wound has been cleaned and examined.*		
Wound, simple repair (less than 2.5 cm)	• scalp, neck, axillae, external genitalia, trunk, hands, feet • face, ears, eyelids, nose, lips, and/or mucous membranes	$112.00 $134.00
Wound, simple repair (2.6 to 7.5 cm)	• scalp, neck, axillae, external genitalia, trunk, hands, feet • face, ears, eyelids, nose, lips, and/or mucous membranes	$133.00 $147.00
Wound, complex repair (less than 2.5 cm)	• forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet	$427.00
Wound, complex repair (2.6 to 7.5 cm)	• scalp, arms, and or legs	$527.00
Breathing Treatment **Multiple breathing treatments may be necessary*	Inhalation treatment for acute airway obstruction Supplies Medications, price per dose. **dosage varies by patient*	$ 21.00 $ 4.00 $ 2.00
Durable Medical Equipment		
Crutches		$ 25.00
Arm sling		$ 10.00
Ace wrap		$ 3.00
Finger splint		$ 10.00
Post op shoe		$ 20.00
Ankle brace		$ 35.00
Pneumatic walker		$ 60.00
Back Brace		$ 75.00

PLEASE NOTE

All labs will be billed separately by Quest Diagnostics. We are unable to estimate costs for labs.

I have read the fees above and understand they are only estimates. Additional charges may apply. I understand the level and complexity of care can only be determined by the provider once I have been evaluated.
I understand I have the right to ask for the price of a procedure or test prior to it being completed, but that no charge can be denied once performed.
I understand I will be required to pay $115 prior to being examined. This money will be applied to my final bill. I will be required to pay the final balance of my visit at the day of service.

Patient/Guardian Signature: _____ Date: _____