EXECUTIVE HEALTH

PROGRAM

2012 Standard Protocol & Optional Services Form | *Florida Campus*

Name: ____________________ Date of Birth: ____________________

Daytime Phone: ____________________ Requested Appt. Date: ____________________

Initial Visit

39 Years and Younger	40 - 49 Years	50 Years and Older
• Physical Exam • Laboratory Work • Resting ECG • Chest X-Ray • Exercise/ Treadmill ECG • Body Composition Testing • Pelvic Exam (women)	• Physical Exam • Laboratory Work • Resting ECG • Chest X-Ray • Exercise/ Treadmill ECG • Body Composition Testing • Pelvic Exam (women) • Mammogram (women) • PSA (men) • AudiOgram	• Physical Exam • Laboratory Work • Resting ECG • Chest X-Ray • Exercise/ Treadmill ECG • Body Composition Testing • Pelvic Exam (women) • Mammogram • Bone Density Scan** • PSA (men) • U/S Abdom. Aortic (men)* • Audiogram • Colonoscopy
Estimated prices: Men: $3000 Women: $3200	Estimated prices: Men: $3500 Women: $3900	Estimated prices: Men: $6900 ** Women: $8000 * Men 60+ Years: $7600 ** Men 65+ Years: $8400

Recommended All Ages – Executive Nutrition Consultation: $150

Subsequent Visits

39 Years and Younger	40 Years and Older
• Physical Exam • Laboratory Work • Resting ECG • Body Composition Testing • Pelvic Exam (women)	• Physical Exam • Laboratory Work • Resting ECG • Body Composition Testing • Pelvic Exam (women) • Mammogram (women) • PSA (men)
Estimated prices: Men:$1900 Women:$1900	Estimated prices: Men: $2000 Women: $2400

Estimated prices are age and gender specific. Additional testing or varied testing may be ordered by the physician as clinically indicated.

Please note additional services may extend the length of your exam.

Additional charges are added if biopsies are performed at time of colonoscopy or endoscopy.

A fee may be charged for appointment no-shows or those rescheduled/canceled within 10 business days of appointment.

Optional Services

The standard Executive Health Program inclusions are listed on the reverse. Additional services, such as those listed below, can be provided at additional costs. If you have specific health care concerns that you want to have addressed by a Mayo Clinic Specialist, please check those services of interest you want to add to your schedule.

To request, check box		Estimated Prices
☐	ALLERGY Consultation (Prerequisite: Allergy Testing)	$300 - $700
☐	Consultation including Allergy Testing	$2700 - $3000
☐	CARDIOLOGY Consultation Reason for request: ____________	$300 - $700
☐	Exercise Treadmill Test (if not already part of Recommended Package)	$720
☐	Coronary Artery CT Scan	$650
☐	DERMATOLOGY Consultation Reason for request: ____________	$300 - $700
☐	GASTROENTEROLOGY Consultation Reason for request: ____________	$300 - $700
☐	Colonoscopy Procedure, without biopsy (if not already part of Recommended Package)	$3280
☐	Consultation plus Upper Endoscopy (for indigestion/ reflux)	$4400
☐	Consultation plus Upper Endoscopy with Dilation (for difficulty swallowing, etc.)	$4435
☐	GYNECOLOGY, Surgical Consultation Reason for request: ____________	$300 - $700
☐	NEUROLOGY Consultation Reason for request: ____________	$300 - $700
☐	OTOLARYNGOLOGY (Ears, Nose, Throat) Consultation Reason for request: ____________	$300 - $700
☐	Ear Wax Removal	$235
☐	ORTHOPEDIC Consultation Reason for request: ____________	$300 - $700
☐	X-ray, body specific area, each	$150 - $700
☐	PHYSICAL MEDICINE & REHABILITATION Consultation Reason for request: ____________	$300 - $700
☐	PULMONARY Consultation Reason for request: ____________	$300 - $700
☐	Spirometry (Lung Function testing, limited)	$200 - $400
☐	CT Scan (Lung Cancer Screening)	$1400
☐	RHEUMATOLOGY Consultation Reason for request: ____________	$300 - $700
☐	UROLOGY, Surgical Consultation Reason for request: ____________	$300 - $700
☐		
☐	Blood Tests or Immunizations	
☐	HIV Test	$200
☐	Immunizations Needed	Prices Vary
☐	Other Services	
☐	Bone Density	$700
☐	Eye Refraction for Glasses with Glaucoma Screening	$400
☐	Eye Exam for Contacts	$400
☐	Other: ____________	

I understand that the services above may not be covered by my insurance and/ or paid by my employer.

Signed By: ______________________________ Date: ______________