ALLERGY MD

PATIENT'S FIRST NAME:_____ M.I.:___ LAST NAME:_____

CREDIT CARD TYPE: ____VISA ____MASTERCARD ____AMEX ____DISCOVER

CREDIT CARD NUMBER:_____

EXPIRATION DATE:_____ CVV CODE:_____ ZIP CODE:_____

TESTING *(please initial)*

_____Skin testing is a method of testing for allergic antibodies. You may be tested to airborne and/or food allergens. If you have a specific allergic sensitivity to one of the allergens, a red, raised itchy bump will appear on your skin within 15 to 20 minutes. These reactions will gradually resolve over the next 60 minutes. Occasionally local swelling at a test site can occur, 4 to 8 hours after the skin tests were applied. Please let the physician know if you are pregnant or taking beta-blockers. Skin testing will be administered with a physician present since occasional reactions may required immediate therapy. Averse reactions to skin testing occur very rarely. In the event a reaction occurs, the staff is fully trained in the treatment of adverse reactions. After skin testing, the physician will go over the results and provide further recommendations. By signing this form, you have reviewed the above information and had the opportunity to ask questions about the test with your physician. You are also aware that skin testing may apply towards your deducible and/or co-insurance. You have reviewed your benefits with your insurance company prior to undergoing this testing. Codes used for your visit can be found on our website www.allergymd.nyc

NO SHOW/CANCELLATION POLICY *(please initial)*

_____We request cancellations to be done 24 hours prior to the scheduled visit. If you cancel less than 24 hours prior to the scheduled visit or are a no show, you will be charged $100.00.

You will be reimbursed your $100 charge, if you complete your visit at another date and time. If you cancel the rescheduled visit, you will be charged another $100.00 fee

Please note the $100 cancellation fee cannot be submitted to insurance and is the sole responsibility of the patient. Please make every effort to attend your scheduled visit.

CREDIT CARD POLICY

Every patient must store a credit card on file. You credit card information will be held securely. We will submit a bill for every office visit and await payment from your insurance company. If a portion of the bill applies to the patients responsibility, your credit card will be used to secure that portion. The Explanation of Benefits will be provided by your insurance company and it will provide all necessary details. Charges that do not successfully process or are denied through your credit card will remain your financial responsibility. Any charge that has not been paid within 30 days from the last visit, will incur a late charge of $35.00. Any account that has not been paid 120 days from the explanation of benefits, will be sent to collections. We will not be able to reverse any accounts that have been sent to collections.

If you choose to not leave your credit card on file, you must pay your estimated costs on the day of the visit. Any monies that are to be returned will be done so within 30 days of notification from your insurance company to our office.

Printed Name:_____ Date:_____

Signature:_____