



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 require immediate therapy. Adverse 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 copay, deductible 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](http://www.allergymd.nyc). We check your benefits as a courtesy and do NOT guarantee the information your insurance company provides. We recommend every patient obtaining their own benefits from their respective insurance provider.**

**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 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

\_\_\_\_\_ If you no show your visit, you will be charged \$100.00 and this is non-refundable.

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. Your credit card information will be held securely. We will submit a claim for every office visit and await payment from your insurance company. If a portion of the bill applies to the patient's responsibility, your credit card will be used to secure that portion. **You will receive a statement from our office in your patient portal on Mondays for review.** 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: \_\_\_\_\_