

New Patient Cancellation Policy

Welcome to our practice and thank you for choosing us! We appreciate your confidence and goodwill. Your appointment will take approximately 2 hours.

- **Please be aware that there is a last minute cancellation charge of \$225.00.** Patients must give at least 24 hours notice; please call 908-522-9696. The fee of \$225.00 can be credited back to your account if you actually proceed with a new patient consultation.
- **Patients who are 15 (or more) minutes late may have to reschedule their appointments.**

Patient Instructions for New Patients/Skin Testing

3 days or 72 hours before your testing appointment please stop taking the following medications:

- **Antihistamines, Decongestant/antihistamine combination medications, *see list below***
- **Astelin**, a prescription nose spray antihistamine
- Any **over the counter allergy medicines, cold & cough remedies**
- Any **over the counter sleep aids**, they usually contain a sedating antihistamine
- **Vitamin C**, if you are taking **1000 mg or more**: large doses act as a natural antihistamine

Please review these lists of medications. If you are not certain if you are taking a product that contains an antihistamine, ask your pharmacist or call this office.

Contain antihistamines	Decongestant/Antihistamine combinations
<p>Actifed (Triprolidine) Alavert Allegra (Fexofenadine) Antivert or Bonine (Meclizine) Astelin (dispensed as a Nose Spray) Atarax (Hydroxyzine) Benadryl (Diphenhydramine) Bromfed (Bromphenamine) Chlortrimeton (Chlorpheniramine) Claritin (Loratidine) or Clarinex Dramamine (Dimenhydrinate) PBZ (Tripelenamine) Periactin (Cyproheptadin) Phenergan (Promethazine) Polyhistine (Phenyltoloxamine) Semprex (Acrivastine) Tavist (Clemastine) Tylenol PM Unisom (Doxylamine) Zyrtec (Cetirizine)</p>	<p>Allegra D Claritin D Naldecon Polyhistine D Rynatan Tavist D Trinalin Repetabs Zyrtec D</p> <p>Most over the counter cold, cough medications</p>

You should continue to take as prescribed the following medications:

- **Antibiotics**
- **All asthma medications**
- **Prescription nose sprays**, with the exception of **Astelin**, which is an antihistamine
- **Decongestants that are not combined with an antihistamine**

Please dress accordingly: the first phase of testing (prick tests) are done on the forearm and the second phase of testing (intradermal tests) are done on the upper arms.

Patient Information

Patient Name _____ Home Phone: () _____

Mailing Address: _____ Cell Phone: () _____

City: _____ State: _____ Zip Code: _____

Email: _____

Sex: Male Female Age: _____ Birth date: ____/____/____

Marital Status: Single Married Divorced Widowed Domestic partner

Who may we thank for referring you? _____

In Case of an Emergency, Contact: _____ Phone: () _____

Insurance Information

All co-pays and self-pay services (SLIT & medical supplies) are expected to be paid the day of service

Primary care MD: _____

Primary Insurance Company

Secondary Insurance Company

Subscriber: _____

Subscriber: _____

Sex: Male Female

Sex: Male Female

Date of Birth: _____

Date of Birth: _____

Relationship to insured: _____

Relationship to insured: _____

Assignment and Release

I, the Undersigned, have my insurance with _____
(Name of Insurance Company)

and assign directly to the **Allergy Diagnostic And Treatment Center** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature

Date

Financial Policy

In an effort to provide the best allergy specialty care at the lowest possible cost to you, our financial policy is designed to clearly define your responsibility for payment and our role in assisting you with insurance reimbursement for services you receive. We participate in most insurance plans, and bill to primary and secondary insurances. If you have any questions about our participation, please contact your insurance company or call our office. **If we do not have a contractual agreement with your insurance company, payment for office services is due at the time services are rendered.** We accept cash, check and credit card payments.

Please be aware that **some insurance companies have a limit on their allergy benefit/coverage.** Also, not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You should verify your benefit/coverage **before** making an appointment.

We will gladly discuss proposed treatment and answer any questions relating to your insurance. You must realize, however, that--

1. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowances determined by each carrier. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
2. **For each month greater than 30 days that your outstanding bill remains unpaid, you will be assessed a 5% finance charge.**
3. If your insurance requires a co-pay for **specialist or allergy shots** as explained in your insurance information your co-pay will be collected **before** services are rendered. **There will be a \$10.00 surcharge if the co-pay is not paid at the time of the visit.**
4. If your insurance is an HMO, you are responsible to supply this office with the referral and/or authorization forms **prior** to being examined. **Failure to do so may result in denial of coverage, the fees for which you will be held responsible.**
5. **You are responsible for informing us of any changes in your insurance plan or policy.** Failure to do so may result in denial of coverage, the fees for which you will be held responsible.
6. If you do not have the proper forms described in your insurance handbook, then you **MUST** reschedule or, if your plan offers "Out of Network" benefits, then you may be seen as an "Out of Network" patient which may result in a somewhat higher cost to you.
7. **No show appointments** will result in a \$225.00 no-show fee for **new patients**, and a \$50.00 no-show fee for **established patients**. **Cancellation with less than 24 hour notice will automatically result in a \$50 no show fee.** Patients will not be able to reschedule their appointments until the no show fee is paid in full. **Returned checks** will be subject to additional collection fee of \$25.00 or greater.
8. **For any forms completed by our office a \$10 charge will be assessed.**

We will do our best in the filing of insurance claims, however, all charges are ultimately your responsibility.

I understand and agree to the Financial Policy of the Allergy Diagnostic and Treatment Center.

Signature of Patient (Guardian).

Date

Print Name of Patient

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from
 Print Patient Name
 the Allergy Diagnostic and Treatment Center, LLC.

X _____ **Date:** _____
 Signature of Patient/Parent/Legal Guardian/Authorized Person

I wish to be contacted in the following manner (check all that apply).

- | | |
|--|---|
| <p>Home: Phone: (____) _____</p> <p><input type="checkbox"/> OK to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call back number only</p> <p><input type="checkbox"/> OK to fax home: (____) _____</p> <p><input type="checkbox"/> OK to mail my home address</p> | <p>Work: Phone: (____) _____</p> <p><input type="checkbox"/> OK to leave message with detailed information</p> <p><input type="checkbox"/> Leave message with call back number only</p> <p><input type="checkbox"/> OK to fax work (____) _____</p> <p><input type="checkbox"/> OK to mail my work address</p> |
|--|---|

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that the Allergy Diagnostic & Treatment Center may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to such. In that case, the Allergy Diagnostic & Treatment Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to such. I designate the following persons listed below as persons involved in my health care or payment relating to such. For the purpose of ADTC making the limited disclosures described above. (I understand that I am not required to list anyone and that I may change this list at any time in writing.

Print Name of each designated person below:	Date of birth:

Staff Only:

In lieu of patient signature, I, _____, a staff member of the
 Print Name of Staff Member

Allergy Diagnostic and Treatment Center, LLC, state that _____ has
 been given our current Notice of Privacy Practices.

Date: _____