Patient Name _____ *Patient #* _____

ALLERGY BILLING POLICIES

It has been recommended that you be tested for a possible allergic component to your symptoms. If your testing reveals allergies, your physician may recommend immunotherapy to desensitize you to the allergens causing you difficulty. The immunotherapy consists of a series of injections of a diluted serum mixture of allergens custom-mixed for your allergies. We will make the serum for you and you may receive your injections either in one of our offices or from your family doctor. In hopes of avoiding later confusion, we would like to explain some of our billing policies regarding this treatment.

From prior experience, we know that some insurance plans do not cover allergy services (Anthem BC/BS for various plans, and United HealthCare being some examples). **You will need to check with your insurance company to see if allergy testing and immunotherapy are covered benefits and how much they will pay for this service, so you will know the amount of your personal responsibility. Also, check to see if a referral from your primary care physician or other prior authorization is needed for this service, as it will be your responsibility to make sure we have that before the testing, making of serum, or administration of injections or the entire cost will be your responsibility.** If predetermination is necessary, our office can help with that process. However, we have found this process can take from a few weeks to several months and may delay testing and eventual treatment of your condition and is not a guarantee of payment. Initials____

The CPT ("Current Procedural Terminology") codes for the skin testing are 95004, and 95024, the mixing of serum is 95165, and for the shots is either 95115 (for a single injection) or 95117 (for multiple injections given at one visit).

SKIN TESTING
Allergy skin testing involves a visit to our office. You will be tested for your reaction to specified allergens selected on the basis of your symptoms and description of factors in your daily living environment (for example, whether you have a dog or cat). The charge per allergen and control tested is $15.00, and you may be tested for up to thirty-five (35) allergens, plus three (3) controls. Total charges for testing will be, therefore, approximately $747.00. **Initials____**

RAST TESTING
We may recommend your testing be done by an analysis of your blood in certain circumstances: 1) to test for food allergies, 2) for patients too young to undergo skin testing, or 3) if the results from your skin testing are inconclusive and/or inconsistent with your symptoms. We may be able to perform this test, if your insurance permits; otherwise we will give you a written order for you to take to a clinical laboratory contracted with your insurance company. Our charges for the Radio Allergo Sorbent Test is $20 per allergen tested and you may be tested for twelve (12) to fifty (50) allergens. Total charges for RAST will be from $240 to $1000. Initials____

TEST RESULTS
Following your session of skin testing, or after your RAST test results are received from the laboratory, you will have an office visit with your physician to review your results and discuss treatment options. If it is found that you will likely benefit from allergy injections, an immunotherapy treatment plan will be set up.

SERUM

Serum is a dilute mixture of the antigens you will receive as one or more injections at regular intervals. Your allergy serum is custom mixed by our allergy nurses based on your specific allergies and once mixed for you cannot be used for anyone else. Because you are responsible for payment once the serum has been mixed, you will need to make your decision to proceed with immunotherapy before you authorize the mixing of your serum. On rare occasion, serum carefully mixed to the strength directed by the results of specific testing will cause a reaction in the patient significant enough to lead to a decision to discontinue treatment, but this does not change the charge for the serum, and you should proceed with this understanding. If a vial needs to be re-mixed because of your noncompliance to your treatment schedule you will be charged a re-mixing fee of **$25.00**. If at any time you decide to discontinue injections for any reason, a 30 day notice is required in writing to the allergy department. **Initials____**

Serum is charged at the following rate: $180.00 per 5cc vial, or $108.00 per 2.5cc vial. The serum's shelf life, when kept refrigerated as directed, is approximately three (3) months and one vial can provide up to ten (10) injections or (6) injections. Again, if a physician referral or other authorization is needed per your insurance policy, it is your responsibility to obtain that before serum will be mixed and dispensed. **Initials____**

Your account must be kept in good standing in order to continue allergy treatment. If you have an outstanding past balance due, no new serum will be mixed and no injections will be given until your account is made current. **Initials____**

As the serum must be kept refrigerated, if we need to send vials either to you or another physician's office and we cannot feel assured that it will reach its destination and be refrigerated within 24 hours, there will be a $_**25.00** overnight shipping & handling charge. This fee cannot be billed to your insurance carrier. **Initials____**

INJECTIONS

If you choose to receive injections in our office, the cost is as follows: $20.00 per single injection or $26.00 for multiple injections given at one visit. We are obligated to collect any co-pays your insurance company directs are due at the time of your injection. **Initials____**

INSURANCE

For services we understand are covered by your insurance, we will file a claim with them on your behalf. Once we have received all payments expected from your insurance company, or if sixty (60) days have transpired without response from your insurance company, you will be billed for the remaining balance, payment of which will be expected within thirty (30) days. **Initials____**

I have read, understand, and agree to these billing policies.

Signed_____

Patient or Responsible Party

Date _____

Rev9/09