ALLERGY & ASTHMA DIAGNOSTIC OFFICE
ORAL IMMUNOTHERAPY FINANCIAL POLICY and INFORMED CONSENT

This is an agreement between Allergy & Asthma Diagnostic Office and the Patient or Parent of minor child named on this document. In this agreement, the words "you", "your", and "yours" mean the Patient/Parent of minor child. The word "account" means the account has been established in your name or the minor child's name to which charges are made and payments credited. The words, "we", "us" and "our" refer to AADO.

PATIENT NAME: _____ DOB: _____

As a patient at the Allergy & Asthma Diagnostic Office receiving **OIT services including INITIAL OFFICE VISIT CONSULT TO DISCUSS ORAL IMMUNOTHERAPY (OIT), DESENSITIZATION**,
I understand, acknowledge and agree to the following:

- **It is my responsibility to contact my insurance company to verify my benefits and coverage.**

- **Should your insurance benefits deem OIT to be a non-covered service under your plan, it is understood any services in the OIT program denied by your insurance will be due and payable by the patient.**
    - Please use the following CPT codes to discuss with your insurance carrier to verify what your benefits are.
        - Office Visit – NEW 99203, 99204, 99205
        - Office Visit – ESTABLISHED 99213, 99214, 99215
        - Desensitization: 95180
        - Pulmonary Function Test – 94375
        - Spirometry – 94060
        - Ingestion Challenge – 95076 1st 2 hours/ 95079 -Additional Hour(s)
    - Diagnosis Codes: **T78.01xA** Initial Encounter-Anaphylactic reaction -**Peanut**
      T78.01xD Subsequent Encounter-Anaphylactic reaction-**Peanut**
      T78.07xA-Initial Encounter- **T78.07xD** - Subsequent Encounter / Anaphylactic reaction- **Milk**
      T78.05xA –Initial Encounter–**T78.05XD**–Subsequent Encounter/Anaphylactic reaction – **Tree nuts**
      T78.08xA-Initial Encounter – **T78.08xD** – Subsequent Encounter/Anaphylactic reaction- **Egg**

- If my insurance changes, it is my responsibility to contact and obtain new benefit and coverage information before continuing treatment. It is my responsibility to inform AADO of such changes in coverage.
- In the event my insurance company reduces my allowed benefits, I understand that I will be responsible for any remaining balance. I understand, acknowledge and agree that I am ultimately responsible for services deemed "not covered" by my insurance plan.

By executing this agreement, you are agreeing to pay for all services that are received for the Desensitization program.

****Please read all statements fully and initial that you agree and understand.**

_____ **Fees: Peanut/Tree Nut OIT**: A non-refundable fee of $300.00* will be charged ***at your initial DESENSITIZATION appointment***. This fee is for the two-week medical supply at each visit and additional doses required during the desensitization process, up to 3 months on solution. If the patient requires solution beyond 3 months, there will be an additional fee of $30/month.

*Supply charges are **not** covered by insurance and must be paid on or before the first day of desensitization.

_____ **Peanut/Tree Nut OIT-Fragments only** - $75 _____ **More than one (1) Tree Nut Additional** $100
_____ **Milk OIT**: $125 _____ **EGG OIT:** $125
_____ **2nd OIT program: Initial Fee:** $200

_____ **Contracted Insurance:** Insurance is a contract between you and your insurance company. We will submit charges to your primary insurance company. If you have a co-pay, deductible or co-insurance, payment will be due prior to each visit. Based on your plan, your insurance company will provide us with payment and an Explanation of Benefits (EOB), defining the patient responsibility. Any remaining balance, including non-covered charges will be billed directly to you by us and will need to be paid prior to your next visit.

_____**Non-Contracted Insurance/Self-Pay/Out of Network:** All self-pay including any insurance companies with whom we do not have a contract must be paid in full at the time of service.

_____ **Referrals and Pre-Authorizations:** It is your responsibility to check with your insurance company regarding referrals/pre-authorization prior to your appointment. We will not contact your PCP on the day of an appointment seeking authorization. If a pre-authorization is required and not in place, unfortunately your appointment will become self-pay and charges for that day will be due in full. Charges for that day will not be submitted to the insurance company.

_____ **Returned Checks:** Returned check fees must be paid prior to your next visit and we reserve the right to request cash or credit cards for future services.

_____ **No Show/Late Cancellations:**

- **Cancellation of INITIAL Oral Immunotherapy Consult and/or 1st day Desensitization appointments** are required at least one week prior to the appointment. A charge of **$200** for NO-SHOW or late canceled appointments will be added to your account. This charge is not covered by insurance. ***Please be advised, due to limited availability and high demand for appointments, NO-SHOWS may result in dismissal from the program*.**

- **Cancellation of follow-up desensitization appointments** are required at least 24 hours prior to the appointment. A charge of $40 for missed or late canceled appointments will be added to your account. This charge is not covered by insurance and must be paid before any further appointments can be scheduled. ***Multiple missed or late canceled appointments may result in dismissal from the program.***

_____ **Minor Children of Divorced Parents:** Both parents are responsible for medical charges and must sign this policy. Whichever parent brings the child to the appointment will be responsible for paying any charges due at the time of service. If the divorce decree requires the other parent to pay all or part of the treatment costs, it will be the authorizing parent's responsibility to collect from the other parent. It is also the responsibility of the authorizing parent to provide an accurate billing address for the other parent.

This is a mutual and voluntary decision between the Allergy & Asthma Diagnostic Office and me. Once you have signed this agreement, you agree to all the terms and conditions herein and the agreement will be in full force. I understand that failure to pay for services in full including No-Show charges will result in my account being turned over to collection for payment.

Patient's Name: _____ _____

Signature of Patient Date

_____ _____ _____

Printed name of Parent/Guardian Date Signature of Parent/Guardian
(If patient is a minor, Parent or Guardian must sign)

_____ _____ _____

Printed name of Parent/Guardian Date Signature of Parent/Guardian
(If patient is a minor, Parent or Guardian must sign)

_____ _____

Witness Date