Allergy & Asthma
DIAGNOSTIC OFFICE

PATCH TESTING APPOINTMENT POLICY:

Please understand that the medicine used for your testing is drawn up in advance specifically for you and cannot be reused for another patient which results in a direct loss to our office.

As a patient at the Allergy & Asthma Diagnostic Office scheduling an appointment for *any* testing appointments, I understand, acknowledge and agree to the following:

- I have been advised that a reminder phone call for the testing appointment will be made 2 weeks prior to my scheduled appointment.
    - **You must contact the office back within 48 hours of receiving the reminder call to confirm this appointment.** During business hours, please call 315-701-9500 or after hours, you can leave a voice message on the appointment mailbox, Email at patients@allergyaway.com or visit our website at www.allergyaway.com and click on "Contact Us".
- I understand and acknowledge that if this appointment is not confirmed within the 48 hours, the appointment will be automatically canceled.
- If I fail to show for my appointment or do not follow the guidelines below for stopping medications resulting in having to reschedule the appointment, a $75.00 fee not covered by insurance will be added to your account.

PATCH TESTING INSTRUCTION:

The following must be stopped 1 week (7 days) prior to your testing.
****ORAL AND TOPICAL STEROIDS**

Your appointment is _____. Please use this form in the event this appointment is rescheduled. This form will need to be resigned annually. If you have any questions or concerns regarding your testing appointment, please call the office at 315.701.9500 to speak with the triage nurse.

PATIENT NAME: _____ ACCOUNT #: _____

_____ _____
Signature of Patient **(If patient is a minor, Parent or Guardian must sign)** Date

_____ _____
Printed name of Parent/Guardian Date