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.

_____ I have been advised that a reminder phone call for any testing appointment will be made by our TalkSoft/RevSpring service 2 weeks prior to my scheduled appointment via phone, email and/or text message. If your appointment is scheduled less than 2 weeks ~ you may not receive a reminder. Please understand it is your responsibility to know when your appointment is.

_____ 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. We reserve the right to pursue collections for any unpaid balances including those covered through Fidelis insurance.

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".

PATCH TESTING INSTRUCTION:

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

Your appointments are scheduled for _____, _____ and _____. Patch testing is three (3) days and a charge will incur for these 3 days which could result in 3 copayments/co-insurance depending on your insurance. 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

REV: 01.2022