Juan L. Sotomayor, MD, PC
ALLERGY & ASTHMA
Diagnostic Office

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Sublingual Food Immunotherapy (SLIT) Financial Policy

PATIENT NAME:_____ DOB:_____

As a patient at the Allergy & Asthma Diagnostic Office receiving SLIT services, including initial office visit consult to discuss sublingual food immunotherapy (SLIT)/food desensitization, I acknowledge that I have read, fully understand and agree to the following:

- It is my responsibility to contact my insurance company to verify my benefits and coverage.
- If your insurance plan determines SLIT is not a covered benefit or is considered experimental, please understand that any related services not covered by insurance will be the patient's responsibility.

Please use the following CPT codes to discuss with your insurance carrier 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 Up to 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/Sesame**
- **T78.08xA-**Initial Encounter – **T78.08xD** – Subsequent Encounter/Anaphylactic reaction- **Egg**
- **T78.09xA-** Initial Encounter – **T78.09xD** – Subsequent Encounter/Anaphylactic reaction- **Wheat/Soy**

- If my insurance coverage changes, I understand that it is my responsibility to contact my insurance company to obtain updated benefit and coverage information before continuing treatment. I also agree to promptly notify AADO of any changes to my insurance coverage. If I do not notify AADO of these changes, I understand that I may be responsible for any resulting charges.
- If my insurance company reduces coverage or determines that certain services are not covered, I understand that I am responsible for any remaining balance. I acknowledge and agree that I am ultimately responsible for payment for services my insurance plan does not cover.

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

_____A non-refundable start-up fee of $500.00* per food will be charged at your initial visit.
*Program and supply charges are **not** covered by insurance and must be paid on or before the first day of desensitization.
_____There will be an additional non-refundable fee of $100 per food every 6 months for supplies.
_____Contracted Insurance: Insurance is a contract between you and your insurance company. We will submit charges to most primary insurance companies. 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 or charges deemed experimental or inclusive of 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. You are being seen at AADO as a private pay patient. If you are a Medicaid eligible patient, you understand that AADO will not submit charges and that all patient visits are considered self-pay/private. You also understand that you may obtain services from a provider practice that participates with your insurance at no cost to you.

_____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. We reserve the right to request cash or credit cards for future services.

_____Initial SLIT consult and/or rapid desensitization visits, require cancellation at least one week prior to visit. A charge of $200 for no-showed 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-show appointments may result in dismissal from the program.

_____Cancellation of follow-up SLIT appointments requires at least 24 hours notice prior to the appointment. A charge of $40 for no-show 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 no-show or late canceled appointments may result in dismissal from the program. Consistent tardiness to appointments could also result in dismissal from the program.

_____Minor Children of Divorced/Separated 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 agreement represents a mutual and voluntary understanding between the Allergy & Asthma Diagnostic Office and me. By signing below, I acknowledge that I have read, fully understand, and agree to all terms and conditions outlined in this policy, and that this agreement will be in full effect upon signature. I understand that failure to pay for services in full, including applicable no-show charges, may result in my account being referred to a collection agency.

_____	_____	_____
Signature of patient/legal guardian #1	Printed name of patient/guardian #1	Date
_____	_____	_____
Signature of patient/legal guardian #2	Printed name of patient/guardian #2	Date
_____	_____	
Witness	Date	