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

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\OIT & SLIT SELF-PAY INSURANCE WAIVER

DATE _____ ACCT # _____

PATIENT NAME_____

PARENT/GUARDIAN (if patient is a minor)_____

INSURANCE AT TIME OF INITIAL OIT PROGRAM START_____

_____ (initial) I have been informed that the Allergy & Asthma Diagnostic Office is a participating provider for my health insurance, however my insurance carrier may consider the charges incurred for their Oral Immunotherapy (OIT) / Sublingual Immunotherapy (SLIT) program as Non-Covered, Experimental or Inclusive and the insurance carrier may deny these charges. I have made an informed decision to become a patient in the OIT / SLIT Program and agree should payment be denied for *any* reason, I will be responsible for payment.

_____ (initial) I understand that the Allergy and Asthma Diagnostic Office will submit any OIT/SLIT program charges to my active and current insurance carrier on my behalf. I understand that the insurance carrier may consider these charges experimental, non-covered or inclusive of other charges which will result in payment being denied.

_____ (initial) I agree to be seen as a patient at the Allergy & Asthma Diagnostic Office for the OIT or SLIT program listed below.

_____ (initial) I have reviewed and agree with the office OIT or SLIT Financial Policy & Informed Consent and as a selfpay patient, I agree to pay for services in full.

_____ (initial) **MANAGED CARE / MEDICAID FEE-FOR-SERVICE INSURANCE ONLY** (i.e., Fidelis Medicaid, CHP or any government insurance product) I understand that services may be obtained at no cost or lower cost at another provider office. I understand that I am being seen as a *private-pay patient* and that charges will not be submitted to my insurance plan for reimbursement either by the practice or patient.

_____ (initial) I understand that failure to pay could result in my account being turned over to collection for payment.

This agreement is a mutual and voluntary decision between the Allergy & Asthma Diagnostic Office and me. I acknowledge by signing that I have read, fully understand and agree with the above terms and conditions.

_____ _____
Signature of patient or legal guardian Date

_____ _____
Printed name of patient or legal guardian Witness

_____