Allergy & Asthma
DIAGNOSTIC OFFICE

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:
(please initial each line and sign below)

_____ I have been advised that a reminder phone call for any testing appointments 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 reminder. Please understand it is ultimately 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.

_____ Your testing appointment is scheduled with a nurse. Testing results will not be given on the day of testing. A follow up appointment must be made with a Provider to go over the results; please be sure to schedule.

TESTING INSTRUCTIONS:

*The following medications must be stopped **7 days** prior to your testing appointment:

Allegra/ Allegra-D (Fexofenadine)
Xyzal (Levocetirizine)
Zyrtec/ Zyrtec-D (Cetirizine)
Claritin/Claritin-D/Alavert (Loratadine)
Clarinex/ Clarinex-D (Desloratadine)
Atarax/ Vistaril (Hydroxizine)
Semprex-D
Tagament (Cimetidine)
Pepcid (Famotidine)
Axid (Nizatidine)
Zantac (Ranitidine)
VITAMINS, MULTIVITAMINS
VITAMIN C, Significant amounts of Orange Juice
Cyproheptadine (Periactin)

*The following medications must be stopped **3 days** prior to your testing appointment:

Benadryl (Diphenhydramine)
Dimetapp
Tavist/ Tavist D
Patanase, Patanol, Pataday (Olopatadine)
Astelin, Astepro, Dymista (Azelastine)
Chlorpheniramine
Dramamine (Dimenhydrinate)
Cyclizine
Doxylamine
Promethazine

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: 05.2024