Advanced
Allergy, Asthma, &
Immunology Center PA
Dr. Patricia Gomez Dinger

FINANCIAL POLICY FOR SERUM/KIT

Patient Name:_____DOB:_____

Date:_____

Dr. Dinger and/or her Nurse Practitioner/Physician Assistant have recommended allergen immunotherapy.
Your ___ new kit___reformulated kit___refill kit is created specifically for your individual needs. You have been provided information that outlines your responsibilities and you agree to commit to immunotherapy. One of the biggest factors to consider is the time commitment required. Also, in addition to the personal time commitment of immunotherapy, you need to consider the financial commitment required in order to begin the process. We have verified your insurance benefits but those benefits are not guaranteed until the claim has been processed. We advise that you verify your benefits as well, we will be glad to give any codes necessary to do this. You will be responsible for any and all amounts not covered by your insurance company.

Therefore, by signing below I acknowledge and agree with the above information. I acknowledge by signing below that my serum/kit will be made for the entire year in advance. I understand that if I stop early I am still responsible for any and all balances owed for my serum/kit.

Patient/Parent Signature:_____

Serum Cost:_____

Shot Book Date:_____ MA INT:_____