ENT & ALLERGY SPECIALISTS OF VIRGINIA

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Allergy Testing Charges

You have scheduled to see an Allergy Specialist in our office. During your visit today your provider may perform one or more allergy tests in order to determine the nature and severity of your allergy symptoms. The administration of these tests is not included in a standard office visit but are a necessary part of patient care. These tests are performed for diagnostic purposes to help your provider determine an appropriate plan of care.

Under your insurance plan your coverage for these charges may be processed under a *separate deductible*. If your deductible has not been met for the year a portion of the payment for this procedure may be the patient's responsibility.

Initial here _____

At the time of scheduling for your allergy appointment you were advised of the necessity of stopping allergy antihistamine medications prior to your appointment in order to be tested.

If you arrive for your allergy appointment and have taken allergy medication that will affect the outcome of the allergy tests administered, it is your responsibility to inform your provider.

If you have a ***Preferred Lab Card***, please present it to your Provider at the time of service. Once the allergy tests are ordered and sent to the lab no discounts can be obtained and you will be responsible for the amount not covered by your insurance company.

Our office follows accepted billing and coding guidelines. All procedures are performed in the best interest of patient care.

I understand that any allergy tests performed during my scheduled office visit will be billed to my insurance company and a portion of these charges may be my responsibility.

Initial here _____

Many Commercial and Marketplace insurances may not have a copayment but have very high deductibles and a coinsurance amount that is the patient's responsibility. If this is the case with your insurance you will be asked to pay a portion of these charges at the time of your visit.

We have verified your benefits and your current deductible is $_____.
Your remaining deductible amount that has **not been** met is $_____.
You have an additional coinsurance amount of _____%.

Any balance that your insurance company does not pay is your responsibility. If your account balance is not paid within 30 days an additional fee of $50.00 will be added to your account and the new balance will be transferred to TransWorld Inc. for collecting purposes.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

(If patient is under 18 years old)

Guarantor Name: _____

Guarantor Signature: _____ Date:_____

Account # _____
Witness Signature _____

3/31/2016