CENTA
Center for Ear Nose Throat & Allergy

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Allergy Services Informed Consent

Patient Name: _____ **DOB:** _____ **Chart #:** _____

NOTE: You as the patient need to make a choice about receiving these health care items or services.

We anticipate that your insurance company, based on their medical criteria **MAY NOT** pay for the item(s) or services(s) that are described below. Your health insurer does not pay for all of your health care costs. Your insurer only pays for covered items and services when the medical rules are met. **It is your responsibility as the insured to verify which procedures may be covered under your policy.** The fact that your insurer may not pay for a particular item or service does not mean you should not receive it. There are medically necessary reasons our physicians recommend these particular tests. Right now, in your case, your insurer **possibly will not pay for-**

Items or Services:
86001: RAST – Allergen specific IgG (**usually it is IgG which is not covered**) – Charge $20.00 per allergen
*This procedure is found to be important in diagnosing your allergy issues. HOWEVER: it is rarely covered by an insurance company. We discount the amount billed by 50% prior to billing patient.
86003: RAST – Allergen specific IgE – Charge $20.00 per allergen
95004: Allergy Testing, MultiTest (prick testing) – Charge $7.00 per allergen
95024: Allergy Testing, Intradermal Testing – Charge $15.00 per allergen/control
95165: Immunotherapy (Allergy Serum) – Charge $90.00 to $180.00 per vial
95115, 95117: Immunotherapy (Allergy Injection) – Charge $20.00 to $26.00 per injection

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should ***read this entire notice carefully.***

- Please contact your insurance company if you have any questions regarding your coverage for these services.
- **Your maximum cost/fee for allergy testing services (which may be required to be paid upon denial by your insurance company) is $940.00.**

____ Option 1. YES. I want to receive these items or services
Please "X" if this is your choice.
I understand that my insurance company will not decide whether to pay until I have received these items or services. I understand that this office has already determined that these services may not meet the medical criteria for payment and will not be responsible for appealing my claim for these services. *Coinsurance, deductible amounts and co-pays may still apply to these services even if my insurance does pay for these charges.*

___ Option 2. NO. I have decided not to receive these items or services.
Please "X" if this is your choice.
I will not receive these items or services. I understand that my physician recommends these services as medically necessary; however I am financially unwilling or unable to follow his recommendation at this time.

_____ _____
Patient or Responsible Party Signature **Date**

_____ _____
Witness (Staff) Signature **Date**