MRN: _____ DOB: ____/____/_____

PATIENT NAME: _____

PHYSICIAN: _____

REVERE HEALTH ALLERGY & IMMUNOLOGY

ORAL IMMUNOTHERAPY FINANCIAL POLICY and INFORMED CONSENT

This is an agreement between Revere Health Allergy & Immunology and the Patient or Parent of minor child named on this document. In this agreement, the words "you", "your", and "yours" mean the Patient/Parent of minor child. The word "account" means the account has been established in your name or the minor child's name to which charges are made and payments credited. The words, "we", "us" and "our" refer to Revere Health Allergy & Immunology.

PATIENT NAME: _____ DOB: _____

As a patient at Revere Health Allergy & Immunology receiving **ORAL IMMUNOTHERAPY (OIT) services including INITIAL OFFICE VISIT CONSULT TO DISCUSS OIT, DESENSITIZATION**,

I have been informed that the patient is allergic to _____ and I have discussed with my physician the possibility of treatment with oral immunotherapy to reduce my or the patient's risk of experiencing an allergic reaction to this food.

I understand that this procedure involves giving increasing doses of the food to which the patient is allergic in order to achieve a state of immunologic tolerance (desensitization).

I further understand that the oral immunotherapy procedure carries a significant risk of causing a serious allergic reaction, including hives, swelling, bronchospasm with difficulty breathing, loss of consciousness and shock, which may require emergency treatment and hospitalization. Food allergy reactions can be fatal. There is also a risk of eosinophilic esophagitis (EoE) developing. This is an inflammation of the digestive tract that can cause heartburn, food impaction (getting stuck) and may become a chronic condition requiring medication and in some cases surgery.

In consideration of these risks, I agree to carefully follow my physician's instructions and precautions before, during and after this procedure. I recognize that a key part of this procedure involves giving doses of the desensitizing food at home every day. I WILL INFORM REVERE HEALTH ALLERGY/IMMUNOLOGY IF THERE HAVE BEEN ANY MISSED DOSES OF THE FOOD FOR MORE THAN FORTY-EIGHT (48) HOURS. If the patient is a minor, I also agree to provide constant adult supervision for the patient during this procedure, whether the food is provided at the allergy clinic or at home. I understand that oral immunotherapy is a long process that will take months and in some cases years to accomplish and office visits every 1 to 2 weeks will be required. I agree to maintain an appropriate schedule of visits as directed by my physician.

In addition, my doctor has advised me that if the patient fails to continue consuming this food in the recommended quantities on a daily basis, the patient may lose the desensitized state and thus, an allergic reaction may occur if the food is eaten some later time, THEREFORE, I AGREE TO NOTIFY REVERE HEALTH ALLERGY/IMMUNOLOGY AND MY DOCTOR IMMEDIATELY IN THE EVENT THAT THE PATIENT FORGETS OR DECIDES TO STOP THIS FOOD ON A DAILY BASIS.

I understand that treatment may be terminated at the discretion of the physician.

I understand there is no guarantee of success for this program and no reimbursement for failure to complete the process.

I understand, acknowledge and agree to the following:

- It is my responsibility to contact my insurance company to verify my benefits and coverage. Please use the following CPT codes to discuss with your insurance carrier to verify what your benefits are.
  - Office Visit – NEW 99203, 99204, 99205
  - Office Visit – ESTABLISHED 99213, 99214, 99215
  - Ingestion Challenge – 95076 1st (120 minutes)/ 95079 -Additional 60minutes
  - Diagnosis Codes: T78.01XA Initial Encounter-Anaphylactic reaction – **Peanut**
    T78.01XD – Subsequent Encounter-Anaphylactic reaction – **Peanut**
    Z79.018 – Allergy to Peanuts
    T78.07XA – Initial Encounter- Anaphylactic reaction – **Milk**
    T78.07XD – Subsequent Encounter- Anaphylactic reaction – **Milk**
    Z91.011 – Allergy to Milk products
    T78.05XA – Initial Encounter – Anaphylactic reaction – **Tree Nuts**
    T78.05XD – Subsequent Encounter – Anaphylactic reaction – **Tree Nuts**
    Z79.018 – Allergy to other foods, Tree Nuts
    T78.08XA – Initial Encounter- Anaphylactic reaction – **Egg**
    T78.08XD – Subsequent Encounter- Anaphylactic reaction – **Egg**
    Z91.012 – Allergy to Egg

- If my insurance changes, it is my responsibility to contact and obtain new benefit and coverage information before continuing treatment. It is my responsibility to inform Revere Health Allergy & Immunology of such changes in coverage.
- In the event my insurance company reduces my allowed benefits, I understand that I will be responsible for any remaining balance. I understand, acknowledge and agree that I am ultimately responsible for services deemed "not covered" by my insurance plan.

By executing this agreement, you are agreeing to pay for all services that are received for the Desensitization program.

****Please read all statements fully and initial that you agree and understand.**

_____ **Fees: A non-refundable fee of $900*** will be charged ***at the time of scheduling the DESENSITIZATION appointment***. This fee is for 1) initial reusable medical supplies for the entire program and 2) OIT solutions at each visit and additional home doses required during the desensitization process. Solutions/powder (for diluted forms of the food) will be dispensed for 2-3 weeks at each visit.

*****$100 additional fee for egg OIT**

Special circumstances:

***If the patient requires solution beyond 2-3 weeks, there will be an additional fee of $40/month for dilute steps, and $80/month for concentrated steps (>step 8).

***The solutions will be dispensed in a glass bottle. Patients will bring back the same bottle for subsequent up-dosing visits. If the patient requires replacement bottles there will be an additional fee of $10/bottle.

2nd OIT program (for another food): Initial Fee: $800

*Supply charges are **not** covered by insurance and must be paid on the first day of desensitization.

_____ **Contracted Insurance:** Insurance is a contract between you and your insurance company. We will submit charges to your primary insurance company. If you have a co-pay, deductible or co-insurance, payment will be due prior to each visit. Based on your plan, your insurance company will provide us with payment and an Explanation of Benefits (EOB), defining the patient responsibility. Any remaining balance, including non-covered charges will be billed directly to you by us and will need to be paid prior to your next visit.

_____**Non-Contracted Insurance/Self-Pay/Out of Network:** All self-pay including any insurance companies with whom we do not have a contract must be paid in full at the time of service.

_____ **Referrals and Pre-Authorizations:** It is your responsibility to check with your insurance company regarding referrals/pre-authorization prior to your appointment. We will not contact your PCP on the day of an appointment seeking authorization. If a pre-authorization is required and not in place, unfortunately your appointment will become self-pay and charges for that day will be due in full. Charges for that day will not be submitted to the insurance company.

_____ **Returned Checks:** Returned check fees must be paid prior to your next visit and we reserve the right to request cash or credit cards for future services.

_____ **No Show/Late Cancellations:**

- **Cancellation of INITIAL Oral Immunotherapy Consult and/or 1st day Desensitization appointments** are required at least one week prior to the appointment. A charge of **$200** for NOSHOW or late canceled appointments will be added to your account. This charge is not covered by insurance. *Please be advised, due to limited availability and high demand for appointments, NO-SHOWS may result in dismissal from the program.*
- **Cancellation of follow-up desensitization appointments** are required at least 24 hours prior to the appointment. A charge of $40 for missed or late canceled appointments will be added to your account. This charge is not covered by insurance and must be paid before any further appointments can be scheduled. *Multiple missed or late canceled appointments may result in dismissal from the program.*

_____ **Minor Children of Divorced Parents:** Both parents are responsible for medical charges. Whichever parent brings the child to the appointment will be responsible for paying any charges due at the time of service. If the divorce decree requires the other parent to pay all or part of the treatment costs, it will be the authorizing parent's responsibility to collect from the other parent. It is also the responsibility of the authorizing parent to provide an accurate billing address for the other parent.

Revere Health
Allergy, Asthma & Immunology

MRN: _____ **DOB:** ____/____/_____

PATIENT NAME: _____

PHYSICIAN: _____

Advance Beneficiary Notice of Noncoverage (ABN)

These procedures are considered common practice for your medical problem. However, your medical insurance may not pay for these procedures. It is the patient responsibility to check coverage prior to the procedure. You will be responsible for payment if your insurance does not cover these procedures.
Your medical insurance does not pay for everything, even some care that you or your health care provider have a good reason to think you need.

Medication or Procedure*	Reason Your Insurance May Not Pay	Estimated Cost
Office visits, food challenges, and oral immunotherapy (see CPT codes above)	Policy Limits; Non-Covered Item	

WHAT YOU NEED TO KNOW

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading this.

***I consent to the procedures as listed above, and I accept financial responsibility.**
Signing below means that you have received and understand this notice.

Signature:	Date:

Once I have signed this agreement, I agree to all the terms and conditions herein and the agreement will be in full force. By signing this form below, I, Parent/Guardian (and, as applicable, Child), hereby certify that:

1) I understand that failure to pay for services in full including No-Show charges will result in my account being turned over to collection for payment.

2) the nature and purposes of the treatment, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me and I understand them; and

3) I have had the opportunity to ask questions and have my questions answered to my satisfaction; and

4) I acknowledge that no guarantees have been made about the results that may be obtained from the treatment; and

5) I hereby voluntarily consent to treatment with oral immunotherapy.

Printed name of Patient/Parent/Guardian: _____ Date: _____

Signature of Patient/Parent/Guardian: _____ Date: _____

(If patient is a minor, Parent or Guardian must sign)