ALLERGY & ASTHMA CONSULTANTS, L.L.P.
720 W. 34TH ST. # 200 Austin, TX. 78705
(512) 454-5821 Fax: (512) 459-9137

Dear Patient:

The front page of the attached form is the instructions for your skin testing. The back page is the insurance benefit form. Please complete it BEFORE your appointment and bring it with you at that time.

Please check with your insurance company to verify your benefits. Co-pays and deductibles may apply to all visits.

Please allow approximately 2 hours for the testing to be completed. Special testing may take up to 4 hours.

After your testing is completed, you will be asked to schedule a follow-up appointment with the doctor. He/she will review the results of all tests done and will make recommendations as necessary. Allow 30 minutes for this appointment.

I have had the opportunity to read the testing instructions and to ask questions.

_____ _____
Patient's Signature Date

After signing, please bring this form to the receptionist to schedule your skin testing appointment.

Your appointment for skin testing is scheduled on _____ at _____

_____
Scheduler's Initials

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INSTRUCTIONS FOR SKIN TESTING

For further evaluation of your allergic condition(s), your physician has recommended allergy skin testing.

Medications can interfere with skin testing and need to be discontinued **7 days** prior to your appointment. **This includes over-the-counter medications.**

MEDICATIONS TO DISCONTINUE 7 DAYS BEFORE ALLERGY SKIN TESTING:

1. **Antihistamines:** (i.e. Claritin/Loratidine, Zyrtec, Allegra, Clarinex, Benadryl, Xyzal, etc.)
2. **Nasal Antihistamines:** (i.e. Astelin, Pantanase, Astepro, etc.)
3. **Eye drops:** (i.e. Patanol, Pataday, Optivar, Elestat, Zaditor, Visine, etc.)
4. **Some Anti-depressants:** (Amitriptyline, Nortripyline, Seroquet, Mirtazapin, etc.)
5. **Other:** Medications for sleep, cough, gastrointestinal problems
6. _____

Continue taking medications such as nasal steroid inhalers, asthma medications, blood pressure and heart medications, hormones, vitamins, aspirin, etc.

You will be skin tested for the following:

Inhalants (pollens, dust, molds, animal dander)
Foods
Insects (bees, wasps, yellow jackets, hornets, fire ants)
Other _____

Testing will begin by pricking the surface of the skin with multiple sterile plastic devices containing a small amount of allergy antigen. This will be performed on your upper & lower arms or on your back. Intradermal testing may be necessary if the prick/scratch tests are negative. This will consist of placing a small amount of antigen underneath the skin in the upper arms with a small needle. **Please wear a sleeveless or short-sleeved** shirt and **do not put lotion on your arms or back**. **Limit sun exposure prior to testing**. If you are sunburned you will need to reschedule the skin test appointment. **Let us know if there is a possibility that you may be pregnant.**

The testing will take approximately 2 hours (venoms and special testing require 4 hours), so please allow adequate time. You should eat breakfast or lunch prior to your scheduled testing appointment.

IF YOU MUST CANCEL OR RESCHEDULE, PLEASE DO SO WITHIN 48 HOURS **or you may be charged $50.00.** If you have questions or to cancel - **CALL (512) 454-5821**.

Testing results and treatment options will be discussed with your physician at your next office visit.

INSURANCE BENEFIT VERIFICATION

INFORMATION NEEDED PRIOR TO CALLING INSURANCE COMPANY

Patient Name: _____

Patient Date of Birth: _____

Name of Primary Insured: _____

Insurance Company: _____

Insurance Company Phone #: _____

Insured's Policy # or SS#: _____

BENEFITS INFORMATION

Date Verified: _____

Name of Insurance Representative: _____

Is my allergy doctor IN-Network? **Y/N**

Specialist Office Visit Co-Pay: $_____

Do I have a deductible? **Y/N** If yes, have I met my deductible? **Y/N** Amount Remaining: $_____

After I meet my deductible, what % will my insurance cover? _____%

If you have not met your deductible, your co-pay will be collected at the time of service and a claim will be filed with your insurance company. After the insurance company processes the claim, you will receive a bill for the remaining balance due.

PROCEDURE	DESCRIPTION	PROCEDURE CODE	APPLIES TO:
Allergy Skin Testing	Pollen, Mold, Dander	Scratch 95004	Deductible/CoPay
	Pollen, Mold, Dander	Intradermal 95024	Deductible/CoPay
	Venom	95017	Deductible/CoPay
	Drugs	95018	Deductible/CoPay
Allergy Cluster	Rapid Desensitization	95180	Deductible/CoPay
Extract Preparation	Each Vial/ 10 units	95165	Deductible/CoPay
	Build up (4 - 8 vials)		Deductible/CoPay
Allergy Injections	Single Injection	95115	Deductible/CoPay
	Multiple Injections	95117	Deductible/CoPay
	Venom Injection	95145	Deductible/CoPay

REFERRALS/PRE-AUTHORIZATION INFORMATION

Referral: a written/typed form completed by your primary care physician, referring you to the allergist; **must** be received by the day of your appointment.

Pre-authorization: permission given prior to procedure/visit, by your insurance company, authorizing office visits, skin testing, allergy extract preparation, allergy injections, etc.

Are referrals or pre-authorization required for the following procedures?

Office Visit yes/no
Allergy Skin Testing yes/no
Allergy Cluster/Rapid Desensitization yes/no
Allergy Injections yes/no
Extract/Vial Preparation yes/no

Please read and sign the appropriate statement below:

☐ I have verified my insurance benefits for the above procedure(s).

☐ I am willing to proceed without verifying my insurance benefits. I understand that I am responsible for any charges incurred that are not covered by my insurance company.

_____
Signature Date