Weill Cornell Medicine

Patient Name:________________________

MRN:________________________

Agreement of Financial Responsibility for Allergy Patch Testing

Allergy patch testing is a very costly test due to the volume of test panels required as part of the test. Please read the following to understand your financial responsibility:

Our Services and Insurance Plan Coverage

_____ (Pt. Initials) Insurance coverage for allergy and patch testing and treatment varies by insurance company, and can vary by each individual insurance plan offered by insurance companies or employers. If you have questions regarding the extent to which your insurance company will cover our services, please contact your insurance company or our Billing Office @ (646) 962- 3376 PRIOR TO your treatment.

Deductibles and Co-Insurance

_____ (Pt. Initials) Many insurance plans now include annual deductibles requiring patients and their families to pay for medical services up to a specified dollar amount before the insurance company will pay for any medical services. Once the annual deductible has been met, patients may still be responsible for fixed co-payments or a percentage of costs (co-insurance). Deductible and co-insurance balances for our services will be determined by your insurance company when they process your claims. We advise you to contact your insurance carrier to verify coverage and authorization requirements PRIOR TO your treatment.

General Insurance Policy

_____ (Pt. Initials) We will file claims with your insurance carrier provided we have your current insurance policy information available. We cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. Ultimately you, as the patient, are responsible for payment to Weill Cornell Medicine. You should resolve disputed coverage issues directly with your insurer or employer. It is your responsibility to know the details of your insurance contract and whether our physicians are network providers for your particular plan.

I agree to be personally and financially responsible for all services rendered by Dr. Zippin. I also acknowledge reading and being given a copy of this Agreement of financial responsibility.

Patient Signature:____ Date:____________

Witness Signature:____ Date:_____________

CC. Epic Record