ALLERGY & ASTHMA DIAGNOSTIC OFFICE
Juan L. Sotomayor, M.D.
Jill Agne, FNP ● Summer Goetz, FNP ● Katie Klee, FNP ● Anna Salvagno, FNP

WAIVER FOR NON-COVERED SERVICE

I understand that Peak Flow Meter testing may not be covered under my insurance plan, and this may be billed at my own expense at a cost of $12. I understand the Peak Flow Meter testing will be submitted to my insurance company but may result in a "non-covered" service dependent on my insurance coverage.

I have reviewed, fully understand, and agree with the Financial Office Policy of the Allergy & Asthma Diagnostic Office. I acknowledge that the Allergy & Asthma Diagnostic office will provide an estimate of charges for today's visit if requested.

I understand that failure to pay for services in full could result in my account being turned over to collection for payment.

_____________________________________ Date_______________
Signature of Patient
(If patient is a minor, Parent or Guardian must sign)

_____________________________________ Date________________
Witness

______________________________________ DOB________________
Patient Name

CPT: S8110
Out of Pocket: $12

REV: 01.04.23

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