Allergy & Asthma
DIAGNOSTIC OFFICE
Juan L. Sotomayor, M.D. • Ellen B. Schaeffer, M.D. • Jill Agne, FNP • Katie Klee, FNP • Summer Goetz, FNP

Serum Mailing Waiver

DATE _____

PATIENT NAME _____

There will be a fee in the amount of $10.00 for the cost of supplies, postage & handling for the mailing of serum. I understand the fee will be added to my patient account and payable upon receipt of the first billing statement. Non receipt of payment will result in all future serums having to be picked up.

I, _____ *(patient/guardian)* am fully aware that I will be financially responsible in full for the original and replacement serum if ***anything*** (lost, delay, breakage, etc) happens to the serum once it has been mailed from the Allergy & Asthma Diagnostic Office.

Please check the appropriate box below and return this waiver to the Allergy & Asthma Diagnostic Office within 5 days.

☐ I have chosen to send serum via USPS and that the cost of postage will be added to my account. _____ (please initial)

☐ I have chosen to pick up my serum at the Allergy & Asthma Diagnostic Office.

MAIL TO: _____

_____

_____

Signed: _____

Date: _____

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www.allergyaway.com