Steven V. Stryk, MD, FAAAAI
1600 S. Canton Center Road
Suite 360
Canton, MI 48188
Ph#:734-394-2661
www.CantonAllergy.com

PATIENT APPOINTMENT POLICY

We do not accept any form of Medicaid.

- Questions to ask your insurance company before your appointment:
- Will my insurance cover the office visit (CPT 99204 / CPT 99205)?
- Will my insurance cover skin testing (CPT 95004 / CPT 95024)?
- Do I have a deductible that must be met before my insurance company will pay?
- Does my insurance require me to pay an office visit copay?
- Does my insurance require a referral from my primary care doctor?
- Is Dr. Steven Stryk in my insurance network?

If your medical insurance carrier requires a referral, confirm with our office before the day of your appointment, that we have received it. If we have not received the authorized referral, you will need to reschedule your appointment.

Paperwork and prep to complete before your appointment:

- Read and follow the timeline for medications needed to be discontinued for testing.
- Fill out the registration form completely.
- Patients under 18 years must be accompanied by a parent or legal guardian. Guardians must present guardianship papers for photocopying to the permanent health record in our office.
- Please arrive 15 minutes early for check in. Late arrival may result in not being seen by the doctor.

Required at check in:

- Driver's license or State of MI identification with photo.
- Insurance card(s).
- Your completed registration form.
- Your copay and any outstanding balance will be collected before seeing the doctor.

Cancellations: At least a12-hour advance notice of appointment cancellation is required. To cancel an appointment and/or leave a message after-hours, call 734-394-2661.

Appointment No Show Fee: Patients will be charged a No Show Fee if they do not show up or cancel their appointment. A No Show may result in our refusal to reschedule further appointments or include being discharged from our practice.

Prescription Refills: Refill requests can be filled by calling the office at 734-394-2661 during normal business hours. If after-hours you can leave a voice mail message. Prescriptions will NOT be called in after-hours or on weekends/holidays.

Medical Emergencies: In case of a medical emergency, call 911 or go to the nearest emergency room. If there is an after-hour medical question you can call the answering service at 734-572-7459. The answering service will ask for the patient's name, date of birth, telephone number, and reason for the call. This information will be relayed to the doctor.

Canton Asthma & Allergy
Pediatric & Adult Care

Date: _____ Chart # _____

PATIENT INFORMATION

Patient Name: First: _____ Last:: _____ M: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Billing Address (If Different): _____

Home: (____) _____ Cell: (____) _____ Work: (____) _____ Birth Date: _____

SS#: _____ Sex [ ]M [ ]F Marital Status: [ ]S [ ]M [ ]W [ ]D Specialist Co-Pay Amount $_____

Email Address: _____ Employer: _____

Spouse/Partner Name: _____ Phone: _____ Other Emergency Contact: _____ Phone: _____

IF PATIENT IS A MINOR – PARENT/GUARDIAN MUST BE PRESENT FOR MINOR TO RECEIVE TREATMENT

Father's Name: _____ Employer: _____ WorkPhone: _____

Mother's Name: _____ Employer: _____ WorkPhone: _____

RELEASE OF INSURANCE INFORMATION

_____ (√) Initial: I give permission to bill my insurance company and assign payment to Canton Asthma & Allergy, P.C.

Primary Insurance: _____ Policyholder Name: _____ Birth date: _____

Secondary Insurance: _____ Policyholder Name: _____ Birth date: _____

Tertiary Insurance: _____ Policyholder Name: _____ Birth date: _____

RELEASE OF HEALTH INFORMATION

_____ (√) Initial: I consent to messages relating to my health care to be left on my phone numbers(s) on file, including x-ray/lab results.

By law, except for the parent/guardian of a minor and other physicians directly involved in their medical care, we are unable to share patient health information. Please check if you would:

[ ] SOMEONE ELSE PRESENT WITH YOU DURING YOUR APPOINTMENT [ ] DISCUSSING YOUR MEDICAL INFORMATION WITH ANOTHER PERSON

Please list the Name and Relationship of person(s) to whom you give consent. - Consent may be revoked by submitting written notification to our Canton office.

I give permission to share my protected health information with: Name_____Relationship_____

Name_____Relationship_____Name_____Relationship_____

PATIENT CONSENT TO ALLERGY TESTING

_____ (√) Initial: I agree to allergy skin testing being performed. I acknowledge that I am ultimately responsible for any charges for the service provided by Canton Asthma & Allergy. I understand test(s) will be ordered based on the oral history of symptoms I provide today, and/or my doctor's professional medical opinion. This opinion may also be based on medical data provided in previous office notes or laboratory results contained in my medical record.

FINANCIAL POLICY

It is YOUR responsibility to check that our services are covered under your insurance plan. Confirm allergy testing codes (CPT: 95004 /95024) and office visit codes (CPT: 99204 / 99205) are covered services. I have checked that Dr. Steven Stryk is in my insurance network.

OUR relationship is with YOU, NOT your medical insurance company. Your health insurance policy is a contract between you, your employer, and your insurance carrier. All charges for medical services we provide to you are ultimately your responsibility. You may be asked to pay your charges in full should: (1) we have not received payment as a result of your failure to notify us of a change in insurance coverage, (2) you fail to provide information requested by your insurance company (i.e. Coordination of Benefits [COB], etc.), or (3) we have not received payment from your insurance carrier for more than 30 days.

Copay and any outstanding balance will be collected before seeing the doctor. No further services will be provided until the account is paid in full. Canton Asthma & Allergy accepts Cash, Check, Money Order, credit cards and Care Credit. You can also pay your bill on-line through our website at **www.CantonAllergy.com.**

An unpaid balance more than sixty (60) days overdue will be submitted to our Collection Company and is subject to a Collection Fee. The Collection Fee is based on a percentage and is added to the patient balance due. Once an account is submitted to collections, patient payment(s) are collected by them until the account is cleared. Accounts in Collections are reported to credit reporting agencies. A patient with an account in Collections **will not** be scheduled until the debt is cleared and this could result in dismissal from the Practice.

Checks that are returned to us due to Non-Sufficient Funds (NSF) will incur an NSF charge added to original balance and result in our refusal to accept your checks in future.

At least a 12-hour advance notice of appointment cancellation is required. Patients who miss a scheduled appointment will be charged a **"NO SHOW**" fee. To cancel an appointment and/or leave a message after-hours, call **734-394-2661**. A No Call/No Show may result in our refusal to reschedule further appointments and may include being discharged from our practice.

I understand and agree to the Policy terms listed above.

(√)Patient Signature: Printed Name: Date:

(Parent/Guardian if Patient is a Minor)

Witness - Canton Asthma & Allergy, PC:

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Antihistamines and Medications that will affect testing:	Length of time to stay off of medication
Antihistamine and Decongestant combinations Benadryl Chlorpheniramine OTC cold and cough preparations Sleep aids such as Tylenol PM, etc.	48 hours
Allegra\Allegra D \ Fexofenadine Allertec Astelin Nose Spray Astepro Atarax \Hydroxyzine Axi \ Nizatidine Dymista Emadine Eye drops Optivar Eye Drops \ Azelastine Periactin Tagamet \ Cimetadine Vistaril Xyzal \ Levoceterizine Zantac \ Ranitidine Zyrtec \ Zyrtec D \ Cetirizine	5 days
Alavert Clarinex\ Clarinex D Claritin\ Claritin D \ Loratadine Famotidone \ Pepcid Pataday \Patenol \Patinas \ Pazeo Eye Drops	7 days

FOR EXAMPLE:
If your appointment is on a Thursday and the length of time to discontinue your medication is 5 days, take your last dose on the Friday before your appointment.

If you are taking medication for RASH, SWELLING, or HIVES – Do Not Stop! *

* There are medications that affect skin results, including antidepressants (e.g. Elavil) which may be used to treat headaches DO NOT stop taking these medications. As a rule, asthma medications do not affect skin test results and may be continued as prescribed. Please call our office if you have any questions.