MAIN LINE ALLERGY, LLP
www.mainlineallergy.com
Sharon K. Sweinberg, M.D. Jack M. Becker, M.D. A. Geoffrey DiDario, M.D. Janet L. Beausoleil, M.D. Jennifer A. Kannan, M.D.

OFFICE POLICY

- All patients are asked to arrive 10 minutes early. If you arrive 15 minutes late, your appointment will need to be rescheduled.
- Your appointment time is scheduled especially for you. If you are unable to keep your appointment, we require 24-hour notice, to be given during office/business hours. Patients will be charged $25 for missing an appointment without 24-hour notice during office/business hours. There are other patients waiting for those appointment times if you are not coming. Should multiple missed visits occur, our doctor-patient relationship may need to be terminated.
- We will not see walk-in patients, as they disrupt schedules.
- Payment is due at the time of the visit (Cash, Checks, MasterCard/VISA/Discover). There will be a $20 fee for returned checks.
- Prescriptions will not be renewed unless you have seen your doctor within one year. Patients may need to be evaluated more frequently based on medical diagnosis, medications, or illness.
- Patient balances must be cleared prior to the next scheduled appointment unless payment arrangements have been made with the Billing Manager.
- After-hours calls are for emergencies only.
- We close daily for one hour for lunch. The time is different in each office.
- Nurse calls will be answered from 9:00 a.m. until 5:00 p.m.

Insurance/Financial Responsibility

Please familiarize yourself with the terms of your insurance. You will be expected to know if referrals are necessary. You are also expected to know which hospitals, labs, x-ray facilities, etc. you may use. If your insurance company does not cover a particular service, you will be held responsible for payment. Self-paying patients must pay at the time of service. Patients with PPO, HMO and POS plans must pay the co-pay at the time of the visit. Co-pays may not cover total payment. Any additional patient responsibility is due within two (2) weeks of receipt of a statement.

I authorize payment of insurance benefits directly to Main Line Allergy. I understand that I may still be responsible for any amounts not paid by my insurance company such as deductibles, co-pays, co-insurance amounts and/or any non-covered services.

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to processing my claims and/or collecting any monies due relating to such claims. I certify that the information I furnish is true and correct. I know it is a crime to provide information I know to be false.

I HAVE READ AND UNDERSTOOD THE ABOVE OFFICE POLICY.

Print Patient/Parent Name	Signature of Patient/Parent Name	Date

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E-PRESCRIBING CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. e-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Main Line Allergy can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Main Line Allergy to enroll me in the e-Prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Parent/Guardian Date

_____
Relationship to Patient

2019