

**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.  
491 Allendale Road, Suite 223      233 E. Lancaster Avenue, Suite 200      2300 Computer Avenue, Suite K56  
King of Prussia, PA 19406      Ardmore, PA 19003      Willow Grove, PA 19090  
(610) 768-9323      (610) 642-1643      (215) 657-8150  
(610) 768-9325 (Fax)      (610) 642-0245 (Fax)      (215) 657-8152 (Fax)

**POLICY REGARDING REFERRALS/DEDUCTIBLE  
INSURANCE PLANS**

**EFFECTIVE DATE - JULY 1, 2015**

**Patients requiring insurance referrals from primary medical doctors (HMO insurance plans):**

New patients and returning patients who need an insurance referral **MUST** arrive for their appointment with a referral. If a patient does not have a referral, that patient will **NOT BE SEEN**. The **ONLY EXCEPTION** is sick patients who were put on the schedule the same day as their visit (they must sign a waiver form, stating they will be financially responsible for the visit if a referral is not received within 24 hours of the visit).

(Please feel free to contact the office prior to your appointment to confirm that we have received the referral from your primary medical doctor.)

**Patients with deductible insurance plans:**

- New patients must pay \$175 toward their deductible before they can be seen for their appointment if their deductible has not been met.
- Returning patients must pay \$50 toward their deductible before they can be seen for their appointment if their deductible has not been met.
- If the full deductible amount has been met, proof will need to be provided if we cannot confirm it.
- If payment is received from your insurance company resulting in a credit balance, the credit balance will be refunded to you.
- If payment is received from your insurance company resulting in a balance due, the balance due will be billed to you.

By signing, I understand this policy refers to the patient's **current** or **future** insurance coverage, whether an HMO or a deductible plan.

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date