DENIS A. BOUBOULIS, M.D., FACAAI, FAACA.
CHRISTOPHER GENNINO, D.O.
106 Noroton Avenue, Darien, CT, 06820
Phone: (203) 655-9904 Fax: (203)656-1416
http://advanced-allergy.com/

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

Thank you for choosing Advanced Allergy, Immunology & Asthma, P.C. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Advanced Allergy, Immunology & Asthma, P.C strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible.

OFFICE HOURS

Office Phone Hours		Allergy Injection Hours	
Monday	7:30am – 4:30pm	Monday	7:30am – 4:40pm
Tuesday	7:30am – 4:30pm	Tuesday	7:30am – 4:45pm
Wednesday	7:30am – 4:30pm	Wednesday	7:30am – 4:45pm
Thursday	7:30am – 4:30pm	Thursday	7:30am – 4:45pm
Friday	CLOSED	Friday	CLOSED
Saturday	CLOSED	Saturday	CLOSED
Sunday	CLOSED	Sunday	CLOSED

APPOINTMENTS Advanced Allergy, Immunology & Asthma, P.C., is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow up due dates. While we strive to schedule appointments appropriately, emergencies can and do occur. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

OFFICE VISITS

All allergy patients should have one office visit with a physician annually to reevaluate your allergies and treatment. If you are receiving any medications (other than an epi-pen), you must be seen once every 6 months to ensure the treatment prescribed is working for you.

Immunology patients receiving medications/treatment must be seen every 2 to 3 months, unless otherwise specified. This is to revaluate the patient, draw labs, as well as to make any necessary changes to the patient’s treatment plan. As a reminder, phone consultations do not take place of an in office evaluation. If you are receiving IVIG treatment, you may schedule your appointment to coincide with your procedure. *Not adhering to this policy may result in the inability to order or refill medication, vials and lab work.*

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CANCELLATION OF AN APPOINTMENT In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive promptly for all scheduled appointments, or cancel the appointment 48 hours in advance. Non business days, which are Fridays and Sundays, are not included in advance notice calculations. This policy allows us to make better use of our available appointments for those patients in need of medical care. Failure to cancel or re-schedule the appointment/procedure within 48 hours of the scheduled appointment time will result in a $40.00 fee for missed appointment/procedure. This fee will not be submitted to the patient's health plan; it will be directly charged to the patient.

PRESCRIPTION REFILLS & PHARMACY INFORMATION Please inform Advanced Allergy, Immunology & Asthma, P.C of which Pharmacy you use and update us if this should change. For ***all refill requests please directly contact your pharmacy who will contact our office for the refill.*** Please allow one to two business days for refill requests. If the patient is *past due* for an office visit, an office visit may be required for any additional refills. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. Our Practice does not routinely order narcotic pain medicine or controlled substances; therefore you may be required to obtain these medications through pain management or another physician.

FORMS/LETTERS We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Advanced Allergy, Immunology & Asthma, P.C. will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, *please allow 10-21 days for completion of requested forms/letters*. Please be aware at this time that our office does not work with workers compensation or accident claims. We also cannot provide vaccine exemptions for patients residing outside of CT.

Administrative fees for forms/letters are as follows:

Medical Letters/narrations- $25.00 and up depending on length, details & expedited requests
School forms (medications, accommodations, etc.)- $10.00
Disability Forms- $25.00

MEDICAL RECORDS Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner. Medical Record Rates are 1-26 pages @ $0.65, 27-100pages @ $0.50, and 100+ pages @ $0.25. The office medical request form may be requested by contacting the front office or can be found on our website at Advanced-allergy.com.

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LABORATORY DRAW POLICY When having lab work drawn (including standard labs through Quest Diagnostics, or Greenwich Hospital Laboratory), it is the patients responsibility to check with their insurance provider to ensure the ordered labs are covered, ***prior*** to having your labs drawn. *Most of our specialized labs (IGeneX, Galaxy, Moleculara, etc.) are not covered by insurance.* Some laboratory orders may include tests that are considered experimental / not medically necessary. All laboratory orders are optional and you may *opt out if you choose to*. Letters of medical necessity and additional documentation will ***not*** be provided for these tests. Our office is unable to answer billing/claim questions in regards to labs, these questions must be addressed directly with the laboratory (Quest Diagnostics, Galaxy Diagnostics, IGeneX, etc.).

IN NETWORK SERVICES All providers *other than Dr. Bouboulis* participate in most major insurances for allergy visits and procedures. You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Advanced Allergy, Immunology & Asthma, P.C., for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on file by the organization. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received. If we do not participate with your specific health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service.

Please be aware that you as the patient are responsible for contacting your insurance to see if the suggested procedures/testings/vials/allergy injections provided by Advanced Allergy, Immunology & Asthma, P.C. are covered or require any referrals/prior authorizations.

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OUT OF NETWORK/ SELF PAY Currently Dr. Denis A. Bouboulis is **only in network with Medicare.** He does not participate in, or submit paperwork to, any insurance programs, and is considered out of network for private insurances. Our office will provide you with invoices for the office visits which you may submit to your insurance, but coverage is not guaranteed. It is your responsibility to check your coverage with your insurer prior to your appointment so that you are informed as to the coverage, lack of coverage for your visits with us. The office out of network fee schedule is located below. *All payments are required at the time of service.*

OUT OF NETWORK / SELF PAY FEE SCHEDULE

New Immunology Patient (60 minutes) - $1400.00
New PANDAS Patient (60minutes)- $1400.00
New PANDAS Family Members (20 minutes)- $350.00 (each)
Self Pay New Allergy (30 minutes)- $350.00
Self Pay Skin Testing $252**-** $710 **(**per testing)

Follow Up Visit Fees

We reserve the right to change our product's prices at any time without further notice.

1-15 minutes - $190.00
25-40 minutes- $375.00
40+ minutes- $550.00

TYPES OF PAYMENT/ DISHONORED CHECKS Our office accepts [*cash, personal checks, Master Card, Visa, Discover, HSA Cards, & American Express*]. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of [*$40.00*], which shall be due and owed immediately.

COLLECTION OF OUTSTANDING BALANCSE Out of network patients and self pay patient's balances are due at the time of service. All outstanding balances shall be due within 30 days. Balances that remain outstanding for a period of 90 days or more may be referred to our collection agency or attorneys' office. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest accrued.

DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

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By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding and agreement with all the above policies.

____ ______________________

Patient Name (Printed) **Patient DOB**

____ ______________________

Patient Signature Signed Date

If the patient is under the age of 18 please provide the patients responsible parties name and signature.

____ ______________________

Responsible Party/ Guardian Name (Printed) **Responsible Party/ Guardian DOB**

____ ______________________

Responsible Party/ Guardian Signature Signed Date