Allergy and Asthma Center

8115 Old Dominion Drive, Ste 220

Mclean, VA 22102

Tel: 703-992-7065

Dear Patient:

The Allergy and Asthma Center has contracts with many insurance companies. We will bill your insurance company and be reimbursed at an agreed-upon amount for services provided to you, and will only bill you those amounts that your insurance company requires us to bill you as co-payments, deductibles or co-insurance.

However, your insurance plan may not cover all items or services. One example of a service that is generally not covered by your insurance plan is exhaled nitric oxide breath testing because, in our experience, your insurance plan has not yet elected to provide coverage for some emerging technologies.

The exhaled nitric oxide breath test is a non-invasive, simple and safe method of measuring the amount of nitric oxide in your exhaled breath. The test provides physicians with a means of evaluating a patient's response to anti-inflammatory therapy, and helps physicians monitor and optimize such therapy for people with asthma. Your physician will discuss the benefits of exhaled nitric oxide breath testing with you in detail during your visit.

NOTICE OF NON-COVERAGE AND CONSENT TO BE BILLED FOR EXHALED NITRIC OXIDE BREATH TESTING

The Allergy and Asthma Center expects that your insurance company will not pay for the exhaled nitric oxide breath test. Please choose an option below by placing your initials in the space indicated:

Initials

_____ **Option 1**: I elect to receive the exhaled nitric oxide breath test. I understand that if my insurance company does not pay, I am responsible for payment of $25.00. I understand that the Allergy and Asthma Center will always bill my insurance company for the test prior to billing me, and will only bill me $25.00 if my insurance company does not cover exhaled nitric oxide breath test. If my insurance company covers the test, the Allergy and Asthma Center will only bill me any applicable co-payments, deductibles or co-insurance.

_____ **Option 2**: I do not elect to receive the exhaled nitric oxide breath test and I am not responsible for payment.

Patient's Name _____ Date_____

Patient's Signature_____