DIVIDE CREEK, PC

NAME:_____ DATE:_____

PLEASE INITIAL ALL

_____ I UNDERSTAND ALLERGY TREATMENT CAN TAKE UP TO **3-5 YEARS** BEFORE IMPROVEMENT IS NOTICED

_____ I UNDERSTAND I MUST SEE A PROVIDER EVERY **6 MONTHS** WHILE ON ALLERGY TREATMENT TO REVIEW OUR TREATMENT PLAN

_____ I UNDERSTAND I MUST MAKE A CO-PAYMENT AT THE TIME OF SERVICE WHETHER IT IS A VISIT WITH ONE OF THE PROVIDERS, ALLERGY TESTING OR SHOTS

_____ FULL PAYMENT IS REQUIRED WHEN PICKING UP ALLERGY DROPS. AUTOMATIC PAYMENT BY CREDIT CARD IS AVAILABLE

_____ I MUST WAIT **30 MINUTES** WHEN RECEIVING MY SHOTS. **NO EXCEPTIONS**

_____ I UNDERSTAND IF I HAVE PERFUME, AFTERSHAVE OR SMOKE ON MYSELF OR PERSONS WITH ME, I WILL WAIT IN THE WAITING ROOM ON THE ENT SIDE OF THE BUILDING INSTEAD OF IN THE ALLERGY WAITING ROOM

_____ WHEN ORDERING NEW MEDS OR ALLERGY TREATMENT (INCLUDING ALLERGY DROPS) I MUST GIVE **1 WEEKS** NOTICE

_____ I UNDERSTAND TO QUALIFY FOR CONTINUING ALLERGY THERAPY IN YOUR OFFICE I MUST SEE A PROVIDER EVERY **6 MONTHS**

_____ I UNDERSTAND IF I AM TREATED FOR THYROID I WILL FOLLOW UP PER DOCTORS ORDERS

_____ ALL SURGERY PATIENTS RESCHEDULING A POST OP VISIT MUST LET US KNOW THE DATE AND TYPE OF SURGERY SO WE CAN RESCHEDULE WITHIN THE POST OP PERIOD, OTHERWISE THE PATIENT IS RESPONSIBLE FOR THE BILL IF NOT WITHIN THE POST OP PERIOD

_____ PATIENTS NEED TO BE SEEN EVERY **6 MONTHS TO A YEAR** BEFORE PRESCRIPTION REFILLS CAN BE FILLED DEPENDING ON PROVIDERS RECOMMENDATIONS