



Allergy and Asthma Associates, P.C.

PATIENT REQUEST FORM

Patient Name: _____ **Date of Birth:** ____/____/____

Who to call if there's any question about the form: _____ Phone: _____

Self-Carry Epinephrine/Inhaler? **YES/NO**

Self-Administer Epinephrine/Inhaler? **YES/NO**

Has the patient had any anaphylaxis? **YES/NO**

Weight: _____ lbs

☐ I understand I or my child (the patient) must be seen routinely by my/their provider for my forms to be processed. If not I understand an appointment may be required before forms can be completed.

TYPE OF REQUEST: (Choose one per request):

- ☐ School/Camp/Disability Form (provide form) _____
- **Fee:** \$20 for the 1st form for the calendar year & \$10 for each additional form but understand this charge may vary depending on complexity
 - **Turnaround time:** I understand my request will take 5-7 business days to be completed
- ☐ Letter From Provider (please explain) _____
- **Fee:** This is subject to \$25+ fee per provider's discretion
 - **Turnaround time:** I understand my request will take up to 2 weeks to be completed

PAYMENT OPTION: (Choose one):

- ☐ **Option 1:** I agree to pay at the time of pick up
- ☐ **Option 2:** I agree to to receive a **CALL** ☐ or **TEXT** ☐ to settle payment as soon as the form is ready and am aware the form will be sent to me as requested only once payment is received

COMPLETION NOTIFICATION: (Choose one):

- ☐ Send my form(s)/letter(s) via my PRIVIA portal
- ☐ Send my form(s)/letter(s) via FAX to: _____
- ☐ Leave in office for pick up (select one): ☐ STERLING OFFICE ☐ MCLEAN OFFICE

SIGNATURE

_____/_____/_____
DATE

____ FORMS COMPLETED BY: _____ CHARGE AMOUNT \$ _____ # OF FORMS TO BILL _____

****OFFICE USE ONLY****