I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am giving my consent to have the **Isomeric Allergy Test** performed by Pioneer Comprehensive Medical and billed to my insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The procedure code for the **Isomeric Allergy Test** is 95004 and a quantity of 72 units. The billed amount for the **Isomeric Allergy Test** is $600; your insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may allow approx. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as an acceptable amount. I acknowledge that I am responsible for all charges applied to my portion, including deductibles and co-insurance, by my insurance company.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_