APPENDIX A - FEE FOR SERVICE PRICING SCHEDULE

Effective June 1, 2026

Coastal Carolina Allergy & Asthma Associates

Mark Schecker, M.D.

CONSULTATIONS & TESTING	SHOTS, OFFICE VISITS & FOOD CHALLENGE
Initial Consultation (includes Pulmonary Function Test "PFT" as needed): History assessment, evaluation treatment plan and one follow-up visit > Age 12 and older: $500 > Child up to age 12: $400 **Allergy Testing (includes Pulmonary Function Test "PFT" as needed):** > Up to 10 tests: $250 > Between 11 - 35 tests: $350 > Between 36 - 100 tests: $450 **Blood Allergy Testing for Patients who do not get Skin Allergy Testing:** $350 Includes: > Ordering Tests > Interpretation **Note:** Lab fees are not included. **Local Anesthetic Testing:** > Lidocaine testing: $250 (add initial consultation fee if applicable) **Fire Ant Testing:** $350 (add initial consultation fee if applicable)	**Allergy Shot Program:** See Appendix B **Transferring Allergy Shots:** $320 plus $35 per month, includes two follow up visits - For patients who have their own extracts from an outside facility **Biologics (including Xolair):** $35 per shot up to $50 per month maximum > Xolair - every 2 or 4 weeks > Nucala - every 4 weeks > Dupixent -every 2 weeks > Fasenra - 4 weeks x2, then 8 weeks > Tezspire - every 4 weeks **NOTE:** Does not include routine follow up or sick visits **Routine Follow-Up Visit (includes PFT as needed):** $160 **Sick Visit (includes PFT as needed):** $185 **Optional Office Visit Program:** See Appendix C **Food Challenge:** $350 (A 3-hour process conducted at the practice in a controlled environment)

NOTE: The practice reserves the right to change the pricing on this Schedule, or discontinue the Shot Program, with 30-days notice.

COASTAL CAROLINA ALLERGY & ASTHMA ASSOCIATES

APPENDIX B - MONTHLY SHOT PROGRAM AGREEMENT

Print Patient's Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____ Email: _____

I agree to text and email communication (required):

☐ Yes ☐ No

Patient or Guardian: _____ Relationship to Patient: _____

I agree to participate in the monthly Shot Program offered by the practice. The cost of the Program is $125.00 per month per participating patient (the "Shot Program Fee"). Either party can cancel this Agreement at any time by giving 30 days' written notice to the other of intent to terminate. The Shot Program Fee shall be due in arrears on the first (1st) business day of each month, and will cover the services for the month immediately prior. The Shot Program Fee shall be pro-rated for the first month. If the Agreement is terminated by either party before the end of a calendar month, then the Practice shall seek only partial payment for the final month of service based on the number of days of participation in the Shot Program by the applicable patient and (if applicable) any itemized charges for specified services rendered up to the date of termination.

The Program <u>includes</u> the following:

- ✓ Monthly allergy shots, including the shot extracts.
- ✓ All follow-up and sick visits.

<u>The Program does not include</u>:

- ✓ Consultations
- ✓ Allergy testing
- ✓ Blood allergy testing
- ✓ Local anesthetic testing
- ✓ Fire ant testing
- ✓ Biologics
- ✓ Food challenges
- ✓ Sick visits

This Agreement Is Not Health Insurance. The Patient has been advised and understands that this Agreement is not an insurance plan. It does not replace any health coverage that the Patient may have, and it does not fulfill the requirements of any federal health coverage mandate. This Agreement does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff. This Agreement includes only those Services identified in **<u>Exhibit A</u>**. If a Service is not specifically listed in Appendix A, it is expressly excluded from this Agreement.

Non-Participation in Insurance. The Practice does not participate with any commercial health plans, HMO panels, or Medicaid. As such, we will not submit bills or seek reimbursement from any of these third-party payors for the Services provided under this Agreement.

I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in the care of the above-named patient.

The undersigned certifies that he/she has read and agrees to the above and foregoing, and received a copy thereof, and is duly authorized to enter this Shot Program Agreement.

Patient's Signature: _____ Date: ____/_____/____

Or, Guardian's Signature: _____ Date: ____/_____/____

Relationship to Patient: _____

COASTAL CAROLINA ALLERGY & ASTHMA ASSOCIATES

Monthly Shot Program

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Payments are made directly through our secure payment processor.

Patient's Name :_____

PAYMENT INFORMATION

I authorize Coastal Carolina Allergy & Asthma Associates, to automatically bill the credit card listed below as in the amount of $125.00 per month per patient participating in the Shot Program. on the first business day of each month.

CREDIT/DEBIT CARD INFORMATION:

Credit card type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder's name as it appears on credit card: _____

Patient's signature: _____

Date signed: _____/_____/_____

AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

Full Name: _____

Signature: _____

Date signed: : _____/_____/_____

Credit card number: _____

Expiration date: _____/_____/_____ CVC (security code): _____

COASTAL CAROLINA ALLERGY & ASTHMA ASSOCIATES

APPENDIX C – OPTIONAL OFFICE VISIT PROGRAM AGREEMENT

Print Patient's Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____ Email: _____

I agree to participate in the optional Care Program offered by the practice. The cost of the Program is $65.00 per month, per participating patient. Monthly payments will be automatically charged to your credit card on file at the end of each month. Either party can cancel this Agreement at any time by giving 30 days' written notice to the other of intent to terminate.

The Program <u>includes</u> the following:

- ✓ Follow-up visits
- ✓ Sick visits
- ✓ Pulmonary Function Tests (PFTs)

<u>The Program does not include</u>:

- ✓ Initial Consultation
- ✓ Allergy testing
- ✓ Allergy shots or extracts
- ✓ Blood allergy testing
- ✓ Local anesthetic testing
- ✓ Fire ant testing
- ✓ Biologics
- ✓ Food challenges

This Agreement Is Not Health Insurance. The Patient has been advised and understands that this Agreement is not an insurance plan. It does not replace any health coverage that the Patient may have, and it does not fulfill the requirements of any federal health coverage mandate. This Agreement does not include hospital services, emergency room treatment, or any services not personally provided by the Practice or its staff. This Agreement includes only those Services identified in Exhibit A. If a Service is not specifically listed in Appendix A, it is expressly excluded from this Agreement.

Non-Participation in Insurance. The Practice does <u>not</u> participate with any commercial health plans, HMO panels, or Medicaid. As such, we will not submit bills or seek reimbursement from any of these third-party payors for the Services provided under this Agreement.

I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in the care of the above-named patient.
The undersigned certifies that he/she has read and agrees to the above and foregoing, and received a copy thereof, and is duly authorized to enter this Shot Program Agreement.

Patient's Signature: _____ Date: _____

or,

Guardian's Signature: _____ Date: _____

Relationship to Patient: _____

COASTAL CAROLINA ALLERGY & ASTHMA ASSOCIATES

Optional Office Visit Program

AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. Payments are made directly through our secure payment processor.

Patient's Name: _____

PAYMENT INFORMATION

I authorize Coastal Carolina Allergy & Asthma Associates, to automatically bill the credit card listed below in the amount of $65.00 per month, per patient participating in the Care Program, on the first business day of each month.

CREDIT/DEBIT CARD INFORMATION:

Credit card type: ☐ Visa ☐ MasterCard, ☐ Discover

Cardholder's name as it appears on credit card: _____

Credit card number: _____

Expiration date: _____/_____/_____ CVC (security code): _____

Patient's signature: _____

Date signed: _____/_____/_____

AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

Full Name: _____

Signature: _____

Date signed: : _____/_____/_____

Coastal Carolina Allergy and Asthma Associates

Dr. Mark Schecker treats a broad array of symptoms and illnesses including the following.

Common Medical Conditions

Allergy related symptoms
Asthma related symptoms
Dermatologic symptoms
Health management

Ear, Nose, Throat

Rhinitis – Seasonal and Year Round Allergies
Allergic eye conditions (I.e., Conjunctivitis, etc.)
Sinusitis/Sinus Infections
Ear conditions/Infections
Nasal congestion
Sore Throat/ Pharyngitis
Tonsillitis
Flu-like symptoms
Headaches
Vertigo/ Dizzyness

Pulmonary

Asthma
Bronchitis
Cough
Colds
Respiratory conditions

Skin

Hives ie Urticaria/Angioedema
Rashes
Eczema
Other skin conditions

Gastrointestinal

Food Allergy
Eosinophilic Esophagitis
Eosinophilic Gastritis/Colitis
Acid reflux

PROCEDURES & TREATMENTS

Allergy Skin testing

Inhalant – Pollens, Dust, Mold, Animals Food
Insect Venoms – Fire Ants only

Allergy Shots

Inhalants
Venom - Fire Ants only

Xolair

Challenges

Food

Teaching

Environmental Control
Asthma/Asthma Control Plan
Food Allergy/Food Allergy Action Plan
Skin Care /Aesthetics