Allergy Consultants, P.A.

Specialists in Pediatric and Adult Allergy, Asthma, and Sinus Disease

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ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hypo-sensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal. **You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection and it is recommended to carry an epinephrine autoinjector syringe with you 12 hours after your shots.** If the patient is less than 18 years of age, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician (see information sheet).

I have read (if new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician in charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, FOR ANY REASON, I decide not to initiate the allergen immunotherapy program AFTER the vaccines have been made: (for example: pregnancy or a change of mind). I accept full financial responsibility for the charges incurred for the cost of the serum and preparation of the same if the insurance company denies payment for any reason. Vaccines may be prepared up to 1½ weeks prior to my appointment. I agree to obtain prior authorization, if needed, from my insurance plan. Your insurance company might require us to bill out your serums (that are prepared all at once) in monthly amounts of 30 doses per month or more often until all of the doses are billed out. Rules on billing out immunotherapy serums are different for each insurance company.
In the event I do not have insurance coverage, I agree to pay $45.00 for each immunotherapy visit at the time of the visit.

PRINT PATIENT NAME:_____Chart Number:_____

PATIENT SIGNATURE:_____ Date: _____

Parent/Legal Guardian: _____

Witness: _____

As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait.