ADVANCED ALLERGY & ASTHMA ASSOCIATES

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ALLERGEN IMMUNOTHERAPY (ALLERGY SHOTS) CONSENT

PATIENT NAME: _____ DOB: _____

- I have read the Allergen Immunotherapy Information 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. Reactions can include, but are not limited to symptoms such as itching/hives/swelling, nausea/vomiting/diarrhea, runny nose, itchy/watery eyes, coughing/wheezing/difficulty breathing and loss of blood pressure/cardia arrest/shock. Reactions, even though rare, can be severe and very rarely fatal. Delayed reactions may occur after leaving the office. I understand that every precaution consistent with the best medical practice will be carried out to protect against such reactions. I hereby give consent for the patient named above to receive allergen immunotherapy (allergy shots). I further agree that, if there is an allergic reaction to the injections, providers at Advanced Allergy & Asthma Associates have permission to treat said reaction.
- I am authorizing the office to bill allergen extracts, even if, for any reason, I decide not to initiate/continue allergen immunotherapy after the extract has been made. The benefits listed below are only an estimate and may be subject to change. I understand that I am financially responsible for all co-pays, deductibles, co-insurance, non-covered services and unpaid services. **It is further my responsibility to ensure that all new/recurring referral authorizations are on file and up to date or I will be financially responsible for any balance accrued.**

____ I understand that I am responsible for taking an antihistamine at least 2 hours before receiving an allergy injection and that I must have my own Epi-pen on my person before an allergy injection can be administered. I further understand that if I do not follow these guidelines then an allergy injection cannot be administered at that time.

- I understand the need to wait for 30 minutes in the office after each allergy injection, due to the risk of reactions.
- I understand it is my responsibility to come to the office and get allergy shots regularly, as per my treatment plan. I also understand that should I not follow the recommended shot schedule and a mixdown is required, then I am responsible for the $25 charge for each mixdown. I further understand that mixdowns cannot be billed to insurances.
- I understand that is it is my responsibility to inform the office, which location it is that I will be getting allergy shots.
- I understand that last shot is given 30 minutes before we close and it's my responsibility to know the shot hours for the location at which my shots will be administered.

Signature of Patient/Patient Representative/Patient Guardian: _____ DATE: _____

PRINT NAME: _____ Relationship to Patient: _____

INSURANCE CARRIER: **ALLOWED MAX UITS PER YR/MO/DY:**

OFFICE USE ONLY:

Patient requests call for serum responsibility details BEFORE serum is made
Patient DOES NOT request a call before serum is made
Patient requests serum location to be in Fort Worth / Southlake (circle which location)

PROCEDURE	APPLIES TO DEDUCTIBLE/COPAY/COINSURANCE	ADDITIONAL NOTES
Allergy Extracts (95165)		
Allergy Shots (95115/95117)		
# OF UNITS:		

Verification done by: _____ Ref. #: _____ Date: _____
Date given to MIXING DEPT.: _____ HELD FOR: _____
SERUM LOCATION: _____