Epipen demonstrated __________________ Rx given ____________________ IT information sheet given__________________

ALLERGEN IMUNOTHERAPY INFORMED CONSENT

I have been made aware by ____ of the following: During the buildup phase of my allergen immunotherapy (allergy injections), I agree to come every 3-14 days to safely increase my vaccines at every visit. If more than 14 days have passed since my last visit, my dose will be adjusted as necessary. Local reactions are not uncommon. I will monitor the size of the reactions and the length of time they last and inform the medical staff. Systemic reactions occur less commonly and may include hives, wheezing, coughing, tightness of the chest, lightheadedness, faintness, nausea, and vomiting. Although rare serious reactions may result in significant respiratory reactions or anaphylactic shock, which may be life threatening. A serious reaction usually occurs within 30 minutes after an injection. I agree to remain in the medical facility for 30 minutes after my injections and to immediately report any symptom to the medical staff. I will carry an Epipen with me on the day of my injection. I have had the opportunity to have all my questions about allergen immunotherapy answered to my satisfaction. I have been informed of the potential risks of allergen immunotherapy and available alternative therapies. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.
I have been given the Allergen Immunotherapy Information sheet.

Patient/Legal Guardian Signature: ____ Date: ______________________________

Witness Signature: ____ Date: ______________________________

ALLERGEN IMMUNOTHERAPY FINANCIAL AGREEMENT

I have discussed my insurance and payment information with the business staff at National Allergy and Asthma regarding the charges for allergy extract and injections. I agree to obtain prior authorization from my insurance company with the help of the National Allergy and Asthma billing staff. I authorize National Allergy and Asthma to order and prepare my allergy extract and understand my account will be charged and insurance filed for these vials.
I further understand that the final responsibility for the payment of these charges is mine. I understand that the allergy extract is being prepared specifically for me and that if I decide not to start or not to continue with allergy immunotherapy, I will be responsible for the charges. If my allergy immunotheraphy extract expires, I am responsible for the charges. I further understand that my insurance may not cover allergy extract prepared for me which I decide not to use. I also understand that unexpected reactions or interruptions in my injection schedule may result in the expiration of certain vials, causing them to be remade and those additional charges then added to my account. In addition, I realize that I will be billed separately for each individual injection.
The allergy extract vials are the property of National Allergy and Asthma until full payment is made. National Allergy and Asthma reserves the right to stop, discontinue, or hold allergy extract and injections until full payment is made. Furthermore, National Allergy and Asthma reserves the right to not prepare refill allergy extract vials until full payment is made for previously administered vials.
With this knowledge I request the vials be ordered and prepared for me and I consent to any necessary treatment required in the event of an injection reaction.

Patient/Legal Guardian Signature: ____ Date: ______________________________

Witness Signature: ____ Date: ______________________________

ALLERGY INJECTIONS ADMINISTERED AT AN OUTSIDE FACILITY

I would like to have my injections administered at an outside facility. I have read all the information about allergy injections, and I agree that I will not attempt to administer my extract to myself nor will I permit anyone who is not a licensed physician or under the supervision of a licensed physician to administer these extracts. I understand that there will be a $15.00 charge for the processing and shipping of the extract, and I will assume the responsibility of making sure that the extract is refrigerated. I assume all the risks of receiving the injections at an outside facility.

FACILITY WHERE INJECTIONS WILL BE ADMINISTERED: ____

Patient/Legal Guardian Signature: ____ Date: ______________________________

Witness Signature: ____ Date: ______________________________