Adult and Pediatric Allergy and Asthma of CT
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ALLERGY EXTRACTS / IMMUNOTHERAPY CONSENT FORM

Name ________________________________ DOB______________________

Date ____________________

I consent to the mixing of custom allergy extracts for myself / my child ____________________ so I / my child may begin allergy injections (Immunotherapy). I have been educated on Immunotherapy to include the following:

1. Immunotherapy ranges from 5-7 years.
2. For the first 8-12 months, I am required to come every week. This is estimated based on my weekly presence and free of site reactions.
3. I understand that if I do not come in for shots for 10-12 weeks I will have to start the entire process over.
4. It was recommended that I take an antihistamine at least the night before or the day of shots to avoid reactions.
5. If I am ever placed on a beta blocker, I am to notify the office immediately. By being placed on a beta blocker it is imperative that the medication be held the day before and the day of shots. The physician that prescribed the beta blocker needs to be consulted with before stopping the beta blocker. The complications/risks have been discussed with me.
6. I understand that I have to wait in the waiting room for 30 minutes after receiving immunotherapy.

I understand that the extracts will be billed when mixed. The office cannot quote your benefits. It is the patient's responsibility to contact their insurance company to inquire about limitations and out of pocket costs. The procedure/CPT codes you can refer to when speaking to your insurance company are 95117 (administration fee) and 95165 (Antigens/amount of units allowed by the insurance company). If there are any questions or concerns, please contact the office before signing this form.

Signed ________________________ Date________