COASTAL ALLERGY CARE
Caring Accessible Excellence

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DEAR PATIENT

RE: Antigen Injection Consent

AS YOU HAVE AGREED TO START ALLERGY INJECTION THERAPY, AN ANTIGEN TREATMENT SET WILL BE MADE FOR YOU. PLEASE UNDERSTAND THAT THESE ANTIGENS ARE MADE SPECIFICALLY FOR YOU, BASED UPON YOUR INDIVIDUAL ALLERGY TEST RESULTS.

IT IS OUR POLICY TO BILL YOU OR YOUR INSURANCE COMPANY FOR THESE VIALS WHEN THEY ARE PREPARED, UNLESS YOUR INSURANCE REQUIRES BILLING ANTIGENS PER DOSE AS THEY ARE USED. IF YOU SHOULD CHOOSE TO DISCONTINUE YOUR TREATMENTS OR YOUR ANTIGENS EXPIRE AND YOUR INSURANCE REIMBURSES ONLY FOR ANTIGENS USED. YOU WILL THEN BE BILLED FOR ANY REMAINING UNUSED ANTIGENS. IF YOU HAVE ANY QUESTIONS REGARDING BILLING OF ANTIGENS, PLEASE FEEL FREE TO DISCUSS THEM WITH OUR BILLING DEPARTMENT.

I (OR PARENT/GUARDIAN) UNDERSTAND THAT THERE IS A RISK OF LOCAL OR GENERALIZED REACTION TO ALLERGY SHOTS. I AGREE TO WAIT THE PRESCRIBED TIME OF 20 MINUTES AFTER MY SHOT(S) FOR MY OBSERVATION AND MY SAFETY. I WILL INFORM THE NURSE OR DOCTOR OF ANY REACTION BEFORE I LEAVE.

I (THE PARENT/GUARDIAN) UNDERSTAND THAT A MINOR IN MY CARE MAY COME ALONE TO THE MEDICAL OFFICE FOR AN OFFICE VISIT, ANY PROCEDURE OR ALLERGY SHOT. THE MEDICAL OFFICE HAS MY CONSENT AND PERMISSION TO ADMINISTER ROUTINE OR NECESSARY EMERGENCY MEDICAL TREATMENT.

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU UNDERSTAND THESE POLICIES AND PROCEDURES. *I authorize Coastal Allergy Care / Allergy Care Center to order and prepare my allergy extract and understand my account will be charged and insurance filed for these vials. 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 may still be 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. 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/GUARDIAN SIGNATURE **PRINT PATIENT'S NAME / Date of Birth**

Location: ☐ CAM ☐ TO **DATE**_____

Staff Initials _____ **Patient ID** _____

NEW START AIT ☐

OVER

Checklist for Renewal of CPT 95165

Patient:
_____

Acct. #
_____

1. Current Medication Use ☑ Patient is receiving appropriate medication for optimal control.		**2. Response to Immunotherapy** ☑ Symptoms improved ☐ Symptoms unchanged ☐ Symptoms poorly controlled
3. If no evidence of benefit, injections are: ☑ continued ☐ discontinued ☐ patient needs allergy re-evaluation		**4. If immunotherapy >5 years, document justification for continuation** ☑ This was reviewed at last E&M visit and continued AIT elected.
5. ☑ All of the above have been considered in making the decisions to continue immunotherapy.		

Physician's Signature: Cristina Pacheco MD **Date**_____