Northwest Asthma & Allergy Center, P.S.

VENOM IMMUNOTHERAPY (VIT) Refill & Consent Form

1. I would like to continue venom immunotherapy/allergy shots. I understand that this procedure is generally safe but that certain risks accompany any treatment. Local reactions (swelling at the injection site) are common. Generalized reactions are less common and can vary from minor symptoms (itchy throat or eyes, runny nose, sneezing) to a more severe reaction (wheezing, chest tightness, hives). Infrequently, a patient may experience a severe allergic reaction (anaphylaxis). There have been cases of death from allergic reactions caused by allergy injections.

2. I understand that allergy injection(s) should **only** be administered in a medical facility where a Physician, Physician's Assistant, or Nurse Practitioner is present and immediately available to treat any possible adverse reaction. **I understand that I/my child need(s) to remain in a medical setting for thirty (30) minutes after the injection(s).**

1. I acknowledge that **[____ I am not / my child is not] / [____ I am / my child is]** presently taking a beta-blocker medication. I understand that these medications are commonly used to treat high blood pressure, arrhythmias, heart palpitations, tremors, glaucoma, and migraine headaches. They may increase my / my child's risk for a systemic reaction that is resistant to treatment.

   I acknowledge that **[____ I am not / my child is not] / [____ I am / my child is]** presently taking an ACE-inhibitor medication. I understand that these medications are commonly used to treat high blood pressure, congestive heart failure, kidney protection diabetes and for renal protection. They may increase my / my child's risk for a systemic reaction that is resistant to treatment.

   If I am / my child **is not** currently taking a beta-blocker or ACE inhibitor medication, **I agree to notify NW Asthma & Allergy Center if such a medication is prescribed to me / my child.**

2. Patients under 16 yrs age must be accompanied by a parent/legal guardian or authorized adult (*Consent to Treat a Minor* form has been signed.) For minors between 16 and 18 years of age, a parent/legal guardian must complete the *Consent to Treat a Minor* form so that the child may come unaccompanied for allergy shot(s).

3. I have had the opportunity to contact my insurance carried to determine my / my child's coverage for venom immunotherapy. **Billing codes for insurance company are as follows:**
   - **venom mix: CPT 95145 – 95149**
   - **injection codes: CPT 95115 – 1 injection; CPT 95117 – 2 or more injections**

   I understand that I / my child may incur a fee for medical provider review if time since last injection is beyond the protocol.

   For additional billing questions, contact Patient Accounts Dept at 206-527-2577 or via email: ptaccounts@nwasthma.com

   Signed consent forms attached to your email can be sent to info@nwasthma.com for processing.

I have read and understand the information presented in this consent form and have had an opportunity to ask questions. In signing this consent form, I accept full financial responsibility for the cost of the venom extracts and injection fees for me / my child.

______________________________	______________________________
Printed Name of Patient	Date of Birth
______________________________	______________________________
Responsible Party/Guarantor Printed Name	Relationship to Patient
______________________________	______________________________
Patient/Responsible Party/Guarantor Signature	Date
______________________________	______________________________
Healthcare Provider's Signature	Date