Northwest Asthma & Allergy Center, P.S.

ENVIRONMENTAL IMMUNOTHERAPY (AIT) Refill Consent Form

1. I would like to continue immunotherapy/allergy shots. I understand that this procedure is generally safe but that certain risks accompany any treatment. Local reactions are common. Generalized reactions are less common. 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 my/my child's antigen will not be made without my signed consent. I will be notified in 2-4 weeks that my antigen is ready and have been advised to call the office if I have not heard from NW Asthma & Allergy Center within that time frame.

3. With yearly refills, the starting dose will be lowered, and I/my child will receive weekly injection(s) before returning to the maintenance dose. Because of the potential adverse reaction to allergy injections, I am/my child is expected to remain in the office for 30 minutes after each shot. 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).

4. I understand the cost for the antigen can vary depending upon the anticipated dose(s) (based on number of mixes, the starting dose(s), and the dosing frequency) that I/my child will receive. The insurance company will be billed for the anticipated doses that I/my child will receive. The administration of injections is billed separately based upon the number of injections given. I understand that I/my child may incur a fee for medical provider review if time since last injection is beyond the protocol.

5. I have had the opportunity to **contact my insurance carrier to determine my/my child's coverage for allergen immunotherapy.** Billing codes for the insurance company include: antigen mix (95165 for environmental allergens) and injections codes (95115 for 1 injection or 95117 for 2 or more injections).

For additional billing questions, contact Patient Accounts Dept. at 206-512-1150. Signed consent forms can be sent as PDFs to forms@nwasthma.com. In the subject line of the email, please include the **location** of the office that you are seen & the **legal first & last name** of the patient.

I have read and understand the information presented in this consent form and have had an opportunity to ask questions. I accept full financial responsibility for the cost of the antigen (allergy mixture).

______________________________	______________________
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

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