NORTHWEST ASTHMA & ALLERGY CENTER

VENOM IMMUNOTHERAPY (VIT) REFILL CONSENT

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 more severe reactions (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).**

3. Patients under 16 years of 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 and18 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 have had the opportunity to contact my insurance carrier to determine my / my child's coverage for venom immunotherapy. **Billing codes for the 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 the time since the last injection is beyond the protocol. **For additional billing questions, contact Patient Accounts at (206) 512-1150.**

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

I acknowledge that ☐ **I am not/my child is not OR** ☐ **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, diabetes, and renal protection. They may increase my / my child's risk for a systemic reaction 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.**

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

Patient's Name	Date of Birth
Patient Signature	Date
Responsible Party/Guarantor Printed Name ☐ same as above	Relationship to Patient
Responsible Party/Guarantor Signature	Date
Healthcare Provider's Signature	Date

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