



NORTHWEST ASTHMA & ALLERGY CENTER

ENVIRONMENTAL IMMUNOTHERAPY (AIT) REFILL CONSENT

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 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 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 shots.
4. I understand the cost for the antigen can vary depending upon the anticipated dose(s) (based on the 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 on the number of injections. I understand that
5. I/my child may incur a medical provider review fee if the last injection's time frame is beyond the protocol. 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 allergies) and injection codes (95115 for 1 injection or 95117 for 2 or more injections). **Contact Patient Accounts Dept. for additional billing questions at (425) 367-6075. Signed consent forms can be sent as PDFs to forms@nwasthma.com**

I acknowledge that I am not/my child is not OR I am/my child presently taking a beta-blocker medication. **If I am not/my child is not currently taking a beta-blocker medicine, 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. I accept full financial responsibility for the cost of the antigen (allergy mixture).

_____	_____
Printed Name of Patient	Date of Birth
_____	_____
Patient Signature	Date
_____	_____
Responsible Party/Guarantor Printed Name <input type="checkbox"/> same as above	Relationship to Patient
_____	_____
Responsible Party/Guarantor Signature	Date
_____	_____
Healthcare Provider's Signature	Date