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Allergen Immunotherapy Patient Consent Form

Immunotherapy or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last being rare and under extreme conditions. Reactions, even though unusual, can be serious and extremely rarely, fatal. You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician (see information sheet).

I have read and understand the patient information sheet on immunotherapy. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergy shots and extracts (vials containing my personalized allergy shot mix). Extracts will be billed after they are made, even if, for any reason, I decide not to initiate the allergen immunotherapy program. These extracts may be prepared up to 11⁄2 weeks prior to my appointment. I agree to obtain prior authorization, if needed, from my insurance plan.

_____
Signature of Patient or Parent/Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable

*As parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

_____ _____
Witness Date