SAN TAN Allergy & Asthma

4915 E. Baseline Road Suite 112
Gilbert, AZ 85234
Ph (480) 626-6600 – Fax (480) 626-6604

S. Reed Shimamoto, MD ● Kerry Berghoff, FNP-C ● Carly Hopkins, PA-C ● Corey Deberry-Seguine PA-C

IMMUNOTHERAPY PATIENT CONSENT FORM

INT: ____ I understand that Immunotherapy, hyposensitization, 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 under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal.
INT: ____I understand that it is **required to wait in the medical facility where the injection is given 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 entire 30-minute waiting period.
INT: ____I understand that if a guardian other than the parent or legal guardian (must be at least 18 years old) is to bring the minor patient in for an allergy injection, they must have written consent to do so.
INT: ____ 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).
INT: ____I have read (if new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. 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.
INT: ____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.
INT: ____ **I acknowledge that with my signature below, I am authorizing the office to make and bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made**. I have been informed that there is a separate fee for the allergen extract; and the allergy injections. I have been provided the opportunity to go over these costs. I am aware that I may also have a co-pay for my allergen extract and each time I come in for my injection. This will be determined by my insurance company.
INT: ____I agree to pay whatever portion my insurance does not cover. I also agree to pay my co-pay, if necessary, at the time of service.
INT: ____I understand any balance on my account must be paid in full prior to any new serum being made.
INT: ____**I understand that it is the responsibility of the patient to call the insurance company to see if the allergen extract and allergy injections are a covered benefit and what percentage they cover.**

The patient will receive_____shots and will follow the Traditional/Cluster Schedule (This line is indicated by the provider)

Identified Triggers: **SPRING** **SUMMER** **FALL** **GRASS** **MOLD** **CAT** **DOG** **DUST**

Other: _____

PATIENT_____**DOB**_____
(Please print patient's name here)

SIGNATURE_____**DATE**_____
(Signature of Patient, Parent or Legal Guardian)

WITNESS (Signature)_____**DATE**_____

WITNESS (Please print) _____

NOTES_____