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CONSENT FOR IMMUNOTHERAPY

I have completed allergy skin testing. It has been determined that immunotherapy (allergy injections) may be beneficial in the treatment of my allergies. I understand that immunotherapy does not cure my allergic state, but does offer a significant change of improvement. I understand that initial build-up includes receiving injections up to three (3) times per week in a physician's office or clinic. I understand that I must wait **at least 30 minutes** after my injections before leaving the office (due to possible reaction).

I have been given the opportunity to ask questions and receive answers. I understand that there are risks involved in taking allergy injections. Reactions can be local, systemic (generalized), or even fatal.

- _____ *(initial)* – I give permission for the preparation of my extract based on my allergies. I plan to start immunotherapy.

- _____*(initial)* – I have been informed that there is a separate billing charge for my allergy extract initially and with each refill order of extract. I understand that I will also receive a separate invoice for the preparation of my allergy extract. This extract is my prescription and cannot be used on anyone else. I also understand that there is a charge every time I receive an allergy injection. This will be billed to my insurance and I will be responsible for the remaining balance. I have been advised to speak with my insurance company, if I have questions regarding insurance coverage. ADAC billing staff will be able to provide an estimate on the information that we received from your insurance company.

- _____ *(initial)* – I understanding that my extract will contain allergens that were positive on my skin test. Allergens to be included in my extract are on my skin test sheet, that is provided by the nursing staff at time of testing.

- _____ *(initial)* – I will be prescribed an Epi-pen in case of a reaction. It is my responsibility to have the prescription filled at my local pharmacy.

- **Do you take a beta-blocker medication such as: Propranolol, Nadolol, Labetalol, Carvedilol or Timolol?** **Yes** ____ **No** ____

- _____ *(initial)* – I give my permission for my minor child (15+) to receive immunotherapy without my presence. Should an emergency occur, I understand that ADAC will follow standard protocol for treatment.

Most insurance providers cover a portion of the cost of immunotherapy, however, there are many coverage variations. Would you like for someone to contact you regarding your insurance coverage? _____ **YES** _____ **NO**

(Please Print - Patients Name)	DOB
Patient/Guardian Signature	Date:
Witness Signature:	Date:

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1202 E. Butler Rd.
Greenville, SC 29607
PH: 864-627-3800

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