ALLERGY, ASTHMA & SINUS CENTER P.C.

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IMMUNOTHERAPY CONSENT FORM

I have read the information provided in the form titled "WHAT YOU SHOULD KNOW ABOUT IMMUNOTHERAPY." I have signed a consent form stating that I understand the risks and benefits of immunotherapy. I understand that severe and life-threatening reactions can occur after being given an allergy injection. There is no way to predict when or if a reaction can occur since it may even occur after many years of safely getting them. I understand that it is the policy of Allergy, Asthma and Sinus Center P.C. to strictly oversee allergy injections so that reactions can be quickly identified and treated.

_____ I understand that any injection can cause a reaction of (increased) wheezing, hives, nasal congestion, runny nose, vomiting or significantly increased shortness of breath. If this occurs, you must contact our office or go to the emergency room and see the doctor before your next injection.

_____ I understand that any injection can cause a local reaction of redness or swelling or pain on your arm where you receive the injection. This can be a normal reaction, but should be reported to one of the nurses prior to your next injection.

_____ I understand that, prior to receiving an allergy shot, I am to notify the nurse of any illness (such as asthma flare) or new medical conditions (i.e. pregnancy).

_____ I understand that I should postpone my shot visit if I am sick (sinus or chest infection, asthma symptoms of breathing problems or chest tightness) until I am treated or symptoms resolve.

_____ I understand that it may take 6-12 months before improvement is noted, and improvement may be gradual thereafter. Optimum therapeutic results usually require three to five years of desensitization therapy.

_____ I understand that prior to receiving an allergy shot. I am to notify the nurse of any new medications (including a beta blocker for control of your high blood pressure, glaucoma or headache/migraine) that have been prescribed.

_____ I understand that I must wait for at least thirty minutes after an allergy shot (on ALL shot visits) and have my arm examined before I am free to leave.

_____ I understand that I should not perform any strenuous exercises for 2 hours after allergy injections.

_____ I understand that, allergy shots should NEVER be administered outside of a physicians' office or by personnel not trained and equipped to treat anaphylaxis.

_____ I understand that failure to adhere to these policies may result in the physician deciding to stop allergy injections.

_____ I understand that these guidelines are for my safety. If I fail to adhere to them, I accept full responsibility for any reaction to allergy injections that may occur.

_____ For minors aged 17 and under who are not accompanied by a parent for allergy immunotherapy; parent consents to emergency treatment of anaphylaxis in our office, if deemed necessary.

_____ I understand that I cannot get an allergy shot on the same day as my office visit.

_____ I understand and authorize Allergy, Asthma & Sinus Center to bill my insurance for serum charges. Payment by your health insurance company is contingent upon your compliance with immunotherapy. If you become non-compliant with the immunotherapy schedule, it could result in you being financially responsible for the unused serum. We recommend all patients to check their insurance benefits and deductibles prior to initiating allergy immunotherapy.

Printed name of patient _____

Signature of patient or legal guardian if minor_____ Date _____

Health Care Provider Signature _____ Date _____