RICHARD R. ROSENTHAL, M.D., LTD.

Adult and Pediatric Allergic Disease, Asthma and Immunology

Diplomates: American Board of Allergy and Clinical Immunology

ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM & AUTHORIZATION TO MAKE ALLERGY SERUM

Patient Name: _____DOB: _____

I understand that the diagnosis(es) for which I am to be treated is/are (circle):

allergic rhinitis allergic asthma allergic conjunctivitis

atopic dermatitis stinging insect allergy

Treatment Options

There are three ways, often used in combination, of treating allergic responses:

1. avoidance of allergens (substances that trigger the allergy)
2. medication, (both prescribed and over-the-counter)
3. immunization (allergy immunotherapy)

- ✓ I understand that the risk of choosing not to treat allergic rhinitis or allergic asthma with allergen immunotherapy may result in incomplete or partial treatment of, and progression of, disease.
- ✓ I understand that the alternative to immunization (allergy immunotherapy) is to limit treatment to avoidance and medication only.

Benefits of Immunotherapy (Allergy Shots)

The benefits of allergen immunotherapy include fewer symptoms, a lessened need to take medication(s) to control symptoms, and a lessened progression of allergic disease (allergic rhinitis, allergic asthma, allergic conjunctivitis and/or stinging insect allergy).

Risks of Immunotherapy (Allergy Shots)

Immunotherapy, hyposensitization, or allergy injections, should be administered at a medical facility with a medical physician or nurse practitioner, present since occasional reactions may require immediate treatment. These reactions may consist of any, or all, of the following symptoms: itchy eyes, nose or throat; nasal congestion, runny nose, tightness in the throat or chest, coughing , increased wheezing, lightheadedness, faintness, nausea, vomiting, hives, generalized itching and shock. Reactions, though unusual, can be serious and, rarely, fatal.

- ✓ I understand that I am required to wait in the medical facility in which allergy injections are received for 30 minutes after injections are given and to check with a nurse before leaving so that the injection site(s) may be observed and any local reaction assessed. If the patient is less than 18 years of age a parent or legal guardian must be present during the waiting period.
- ✓ I will report any delayed reactions to allergy immunotherapy to the nurse before receiving further injections

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ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM & AUTHORIZATION TO MAKE ALLERGY SERUM, Page 2

Patient Name: _____ **DOB:** _____

- ✓ I verify that I (or minor patient) am/is not taking a beta blocker or ACE inhibitor medication
- ✓ that I have discussed the risks/benefits of taking a beta blocker with my physician/nurse practitioner (see the *Information on Allergy Immunotherapy* handout).
- ✓ I understand that I will inform this office if I become pregnant so that allergy immunotherapy may be postponed or dose stabilized.
- ✓ I have read the above information and the *Information on Allergy Immunotherapy* handout provided to me and understand it.
- ✓ I have been given the opportunity to ask questions regarding the potential side effects of allergy immunotherapy and any such 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 adverse reactions. I also agree that if I have an allergic reaction to allergy immunotherapy injections that the physician/nurse practitioner in charge has permission to treat said reaction.

☐ I acknowledge the fact, with my signature, that I am authorizing the office to prepare and bill for allergy vaccines(allergy extract), even if, for any reason, I later decide not to begin allergen immunotherapy. I agree to obtain, if needed, prior authorization from my insurance plan.

☐ Alternatively, allergy vaccines will be provided by the patient from another practice.

Patient Name (Printed) _____ **Date:** _____

Patient Signature (or Legal Guardian) _____ **Date:** _____

As parent, or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait.

Witness _____ **Date:** _____

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Advance Notice of Non-Covered Services for Allergy Immunotherapy

Some insurance carriers have made recent changes to their contracts with this office that may affect services that the physician deems medically necessary such as the number of allergy injections that a patient is prescribed. These changes by the insurance carriers may result in higher costs to the patient because of:

- Limits on the amount of allergy serum that may be made in one calendar year

For example, if a patient exceeds the amount of allergy serum that may be made in one calendar year, the amount of allergy serum that exceeds the allowable, may be considered a non-covered service and the patient may be billed for that service.

If you have questions about your insurance coverage please call the 800 phone number on the back of your insurance card to ask if there are limits on the amount of allergy serum that may be made in one calendar year and what your responsibility would be for allergy serum that exceeds the amount allowed by your insurance company.

Please make a note for your records of the name of the representative you spoke with and the details of your conversation.

If you determine that your insurance carrier has implemented changes that affect the amount of allergy serum that may be made in one calendar year and you have questions about how much allergy serum you might use in one year please call the office at 703-573-4440 and leave a message with your name and phone number and we will call you.

I understand that my insurance company may have made changes to their contract with this office and that it is my responsibility to call my insurance company to verify my coverage. If services are non-covered I agree to pay the non-covered service in addition to any co-pay, co-insurance or deductible.

_____

Signature Print Name Date