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PATIENT INFORMATION/CONSENT FOR ANTIGEN BILLING

1. **Deposit**:

A $500 deposit fee is required towards the ordering of your Antigen. Your antigen bottle(s) will be made especially for you based on your allergy test results.

2. **Billing**:

When ordering your Antigen treatment, several bottles will be made and billed to get you started on injections for a few months. Antigen is billed to the insurance company by units, with limits on the amount that can be billed each month. Therefore throughout the year you will see Antigen continuously billed to your account until the whole bulk of Antigen ordered is billed.

3. **Refills**:

You will need an antigen refill visit when your antigen is out or if stronger bottles are needed. If you have not seen doctor/provider within the past three months you will need to schedule an appointment. Medicare patient's need appointments for every refill. If you are doing well with your injections we will order a refill for you and bill your insurance with the billing process mentioned above.

4. **Stopping Injections**:

If at any point you decide to stop allergy injections, please notify our staff and schedule an appointment to discuss alternative therapeutic options.

I have read this patient consent for Antigen billing and understand it. The opportunity has been provided to me to ask questions regarding the billing process and these questions have been answered to my satisfaction.

I understand that I am authorizing the allergist to proceed with the making of my Antigen and to bill my insurance as above. I also understand that I am responsible for the billing of my Antigen once it is ordered even if I decide to stop allergy injections at any point during the treatment, and have not used the whole amount of antigen.

Patient Name: _____

Responsible Party/ Patient Signature: _____ Date: _____

Witness: _____ Date: _____

PATIENT INSTRUCTION / CONSENT FOR ALLERGY VACCINATION

1. **Purpose**:

Immunotherapy or "allergy shots" are used to decrease your sensitivity to offending allergens such as pollens, dust, molds, etc. This will permit you to tolerate exposure to allergen with fewer symptoms, hence "immune" to these allergens.

2. **Efficacy**:

Improvement should not be expected immediately, usually requires 3 to 6 months before any relief of allergy symptoms is noticed, and it may take 9 to 12 months for a full benefit to occur. Over 85% of allergic individuals on allergy vaccination get significant improvement.

3. **Procedure**:

Allergy injections are begun at a very low dose. This dose is gradually increased once or twice a week until therapeutic dose (often called maintenance dose) is reached. After the maintenance dose has been reached, injections can usually be given once every 2 weeks. The goal is to eventually spread the injections to every 3 to 4 weeks. (Note: some insurance require monthly shots at maintenance)

4. **Duration**:

It usually takes 6-12 months to reach this maintenance dose. This period will be longer if injections are not received regularly, or if reactions occur along the way. It is recommended to stay on maintenance injections for at least 3 to 5 years.

5. **Adverse Reaction:**

The most common reaction is a lump, swelling or redness at the site of injection which can be itchy, usually resolves within 24 hrs. This type of "local" reaction is not necessarily dangerous, but if it is bigger than a golf ball, please let the staff know. Occasionally systemic reaction can occur after the injection, usually within 15-20 minutes. This reaction may consist of any or all of the following symptoms: itchy eyes, nose or throat, nasal congestion, runny nose, tightness in chest, coughing, wheezing, lightheadedness, fainting, nausea or vomiting, hives and generalized itching and shock under extreme conditions. Reactions can be serious but rarely fatal. Please let the staff know if you are taking beta blockers (a type of heart or blood pressure medication) if you are pregnant, or if you have fever or wheezing, prior to the injection given.

YOU ARE REQUIRED TO WAIT IN THE MEDICAL FACILITY IN WHICH YOU RECEIVE INJECTIONS FOR 20-30 MINS AFTERWARDS. IF YOU ARE EXPERIENCING ANY REACTIONS, NOTIFY THE STAFF IMMEDIATELY!

I have read this patient consent form on allergy immunotherapy/ vaccination and understand it. The opportunity has been provided to me to ask questions regarding the potential side effects of vaccination and these questions have been answered to my satisfaction. I understand every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient (Parent/Guardian): _____ Date: _____

Witness: _____ Date: _____