Timber Lane Allergy & Asthma Associates, PC
53 Timber Lane
South Burlington, VT 05403
(802) 864-0294

Account#:____________________
Phys:________________________
Insurance:____________________
Procedure Code:_______________

CONSENT FORM AND FACTS ABOUT IMMUNOTHERAPY (IT)

Allergy shots are a form of therapy, which can decrease the sensitivity of persons who have allergies. Immunotherapy (IT) is a supplement to environmental control and medical management where those modes of therapy have failed to bring about the desired benefit. Immunotherapy is a significant commitment of time and finances. They must be received routinely as scheduled without interruption to improve likelihood of benefit and minimize chances of adverse reactions. Immunotherapy is typically prescribed for 3-5 years, in some cases longer. Many patients do not see a significant improvement in their symptoms until they are close to a maintenance dose. Immunotherapy may prevent symptoms from occurring; prevent additional sensitizations from taking place and reduce risk of developing asthma, and may reduce severity of existing asthma. It is the only therapy that can alter the natural history of allergic disease. They will not help you relieve symptoms that are occurring at the time of injection.

REACTIONS: Because you are receiving materials to which you are allergic, it is possible that a reaction may occur. There are two types of reactions:

LOCAL: These reactions usually occur within 30 minutes after the injection, although rarely may occur hours later and include redness, swelling and itchiness at the site. Reaction size varies; degree of local reaction does not predict risk of systemic reaction. Local reactions are anticipated to occur in most individuals at some time in the treatment course.

SYSTEMIC: This type of reaction usually occurs within 30 minutes after the injection but rarely may occur many hours after the injection. The symptoms of a systemic reaction include itching (palms, soles, scalp, eyes, ears, etc.), coughing, congestion, sneezing, wheezing, throat tightness and hives. Although extremely rare, deaths from allergy shots have occurred. For this reason, all patients are required to wait 30 minutes after their shots in the waiting room. Any systemic reaction should be reported to our office as soon as possible after appropriate treatment. You should not participate in strenuous exercise for 30 minutes after an allergy shot. All patients on immunotherapy need to carry an Epi-Pen on the day they receive their injection(s).

Under no circumstances may allergy shots be given at home or given without proper physician supervision. **To minimize likelihood of reaction, patients should routinely take an antihistamine on the day of an injection.** Should local reactions become uncomfortable at home or in our office, ice packs and an antihistamine can be given.

We do not administer allergy shots if you are feeling ill, have a fever, are overheated, or are having uncontrolled symptoms of your asthma. Proper medical treatment should be instituted and injections rescheduled. For best results, you should receive your injections on schedule. If you need to be away for an extended period of time, please let us know and arrangements may be made for you to receive your IT elsewhere. Interruptions in therapy will reduce a step back in your schedule; and if extended may require starting over. Revisions in injection protocol required because of missed or late injections potentially increase your risk of allergic reactions to the injections.

Once you are receiving your allergy shots monthly, you are expected to see your allergist on a regular basis at least once per year or more frequently if you have asthma. These visits are important so the doctor can determine the effectiveness of therapy and modify it if necessary. Please notify the nurse or physician if you are taking any new medications, specifically beta-blockers, which are used in the treatment of high blood pressure, heart disease and migraine headaches. Patients on beta-blockers cannot receive IT. If you become pregnant while on IT please notify our office immediately. Immunotherapy may be continued safely during pregnancy; but may require dose adjustments.

I confirm that my doctor has fully explained to me the benefits, side effects, potential complications and risks, and possible alternative to be considered before undergoing the medical treatment or procedures described above. I acknowledge that no guarantees have been made to me concerning the outcome of this medical treatment. With full knowledge and understanding of this information, I consent to and accept all risks involved in the medical treatment and procedures to be performed.

I authorize Timber Lane Allergy & Asthma Associates, PC to order and prepare the vaccines necessary for me to begin immunotherapy. Either my insurance company or I will be billed when the vaccines have been mixed. I will be notified when the vials are ready and I understand that I must start within a week after I am notified as the first vials of allergy vaccine expire within a short period of time. If the vials need to be remixed I understand that I will incur additional charges for the allergy vaccine.

Patient Name:_______________________________ Date of Birth:__________

_______________________________ ______________
Signature of patient or person authorized to consent for the patient. Date
Witness:_______________________________ Date______________

I will start injections at: ☐Timber Lane Allergy & Asthma Associates
☐_______________________________
Other physician's office (please list name of physician)

Revised 1/12 ☐Epi Pen Prescription Given ______ ☐Epi Pen Training Done______ ☐Vaccine Written______________

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South Burlington, VT 05403
Phone- 802-864-0294
Fax- 802-864-3779

PAYMENT AGREEMENT

(This form must be completed and returned with the immunotherapy consent form)

PATIENT NAME: ______________________________________

GUARANTOR NAME: ___________________________________

ACCOUNT #: ______________

All copayments/coinsurance/deductible amounts for injections administered in our office must be paid on the day of each injection. You may check with our Business Office for the amount owed based on your insurance plan. Our office offers three payment options in order to keep your account current with injection payments. Please indicate below which option you prefer.

- ○ Pay on the day of each injection. By choosing this option, I agree to pay any injection copayments/coinsurance/deductible amounts on the day that I am here for my injection.
- ○ Pay ahead for future injections. By choosing this option, I agree to make advance payments on my account. The resulting credit will be applied to my injection balances as they occur. I further agree to make additional advance payments when the Business Office notifies me that my credit balance has been depleted. This option will allow me to receive injections without checking in with the Business Office for as long as I maintain a credit in my account.
- ○ Auto-Pay. By choosing this option, I agree to keep my credit card information on file with the Business Office. I understand that my card will be charged each time that I receive an injection. (You will be expected to provide your credit card information to the Business Office when here for your first injection). This option will allow me to receive my injections without checking in with the Business Office for as long as I provide valid credit card information.

Signature: ______________________________ Date: ____________