Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testing Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This packet contains the following items:

1. Patient Allergy Profile & General Information Questionnaire
2. List of allergy medications to stop taking before allergy testing
3. List of medications which are not compatible with allergy skin testing
4. Allergy Financial Consent/Disclosure and Agreement Form
5. Patient Communication Consent Form
6. Allergy Testing Consent Form
7. Allergy Immunotherapy Consent Form
8. Informed Consent of Office Protocol
9. Patient Consent for Medical Photography
10. HIPAA Privacy Notice
* **Please bring this entire packet with completed forms to your allergy testing appointment along with any referral from your doctor.** If you have any questions regarding referrals, please call the clinic at any time.
* **Please DO NOT apply any lotions, oils, or other moisturizers to your arms the day of testing.**
* **Please *wear a loose/short sleeved shirt* to your appointment so that your arm may be accessed for testing and *bring any inhalers* that you are using to your testing appointment.**
* **For asthmatic patients, make sure to bring your inhaler(s) with you to your appointment.**
* Please **make a list of all the medications you are taking and share them with the Clinical Allergy Coordinator** during the pre-testing phone call and on testing date. This is to ensure the safety and integrity of the medical results.

**NOTE:** Allergy tests are scheduled for **1.5 hours** and **scheduled at least a week in advance**. This is to ensure that the patient has adequate time to **stop taking certain medications prior to the allergy testing date.** If for any reason you must cancel or move your appointment time, please consider that your new appointment time must also be scheduled **at least one week** prior to testing. If you are unable to keep your appointment, please contact the clinic in advance. Any missed appointment is subject to a $50 late-cancellation fee.

***Allergy Services of America, LLC***

**Patient Allergy Profile &**

**General Information Questionnaire**

Carefully complete this form with full, accurate, and thorough information. Be as detailed as possible.

Relate all answers to your own experiences. **This form must be completed prior to your allergy testing.**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City­: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *I would like to receive text message reminders about upcoming appointments.*

 *I would* ***not*** *like to receive any text messages.*

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I would like to receive emails from Allergy Services of America, LLC with updates, tips and other educational information.*

 *I would* ***not*** *like to receive any emails.*

Name of referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Allergy Profile***

What type of allergy do you think you have?

Allergic Rhinitis: \_\_\_\_\_\_\_\_ Asthma: \_\_\_\_\_\_\_\_ Others: \_\_\_\_\_\_ Unsure: \_\_\_\_\_\_\_\_

What medications have you taken for these symptoms and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have Asthma:

 Please list all medications you are taking for it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have any of these medications been helpful? If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you been hospitalized for asthma? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 Have you ever been allergy tested before? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 If yes, please indicate, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received allergy immunotherapy before? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 If yes, what type? Shots\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drops: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 When did you start it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you still receiving immunotherapy? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 If No, how long *were* you receiving immunotherapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Improvement after previous immunotherapy (circle) Good Fair Poor

When approximately did your Allergies begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do your allergies occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (# of times per day, week, etc.)

When are symptoms worse? Early morning \_\_\_\_\_\_ Afternoon\_\_\_\_\_\_ Night\_\_\_\_\_\_\_

How long do the symptoms last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check months that are most severe:** All Months\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| January\_\_\_ | February\_\_\_ | March\_\_\_ | April\_\_\_  | May\_\_\_ | June\_\_\_ |
| July\_\_\_ | August\_\_\_ | September\_\_\_ | October\_\_\_ | November\_\_\_ | December\_\_\_ |

**What do you think makes it WORSE?**

**What do you think makes it BETTER?**

**Do you think you are allergic to any foods**? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ (check below)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Milk\_\_\_ | Cheese\_\_\_ | Eggs\_\_\_ | Fish\_\_\_ | Wheat Products\_\_\_ | Chocolate\_\_\_ |
| Shellfish\_\_\_ | Nuts\_\_\_ | Wine\_\_\_ | Beet\_\_\_ | Vegetable\_\_\_ | Strawberries\_\_\_ |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you think you are allergic to any medications?** Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

If yes, list names of medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of reaction you have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think you are allergic to any insect stings? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Do you think you are allergic to any Latex? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Do you have history of smoking? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 Frequency (amount smoked per day, days per week, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Environment**

Home type (circle) Single Family Apartment Townhouse

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of home (years): \_\_\_\_\_\_\_\_\_

Flooring (circle) Carpet Hardwood Tile Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Central air? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Heating (circle) Forced air Radiator Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indoor mold? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smokers in home? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Occupation of housemates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medical History***

**Do you have a history for any of the following?**

1. High blood pressure Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_
2. Cardiovascular disease Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_
3. Stroke Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_
4. Tested positive for HIV Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_
5. History of severe anaphylactic reaction Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

**Are you pregnant?** Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

**If there is a possibility that you are pregnant please notify the physician before you have the allergy test.**

**List all medications you are currently taking**:

**List all surgeries and hospitalizations**:

**Do you have family history for any of the following? (circle)**

Allergies Asthma Eczema Auto-Immune Disease

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there anything else you would like to mention before testing?**

**Patient Notification:**

**Contraindicated Medications**

Patients who are taking BETA-BLOCKERS (including eye drops) or TRICYCLIC

ANTI-DEPRESSANTS **cannot** get *allergy skin testing*. However, these patients **can** get allergy blood testing *(RAST)*.

Below is a **partial list** of such medications. DO NOT STOP TAKING THESE MEDICATIONS UNLESS DIRECTED BY THE PRESCRIBING PHYSICIAN.

BETA-BLOCKERS: (need to be stopped for 24 prior to testing {**physicians’ decision and *not the Clinical Allergy Coordinator’ decision***}

|  |  |
| --- | --- |
| Acebutolol (sectrol) Corzide  | Penbutolol Sulphate (Levatol) Pindolol (Visken) Propranolol (Inderal) Sectrol Tenoretic (atenolol & chlorothiazide) Timolol malate (Blocarden) Toprol Timoptic ‘*Eye Drops’* Visken   |
| Atenolol (Tenormin) Betapace (Sotalol) Betaxolol (Kerlone) Bisoprolol (Zebeta) Blocardren Bystolic (Nebivolol)Esmolol (Brevibloc) Carteolol HCl (Cartrol) Carvedilol (Coreg) Corgard   | Esmolol Inderal Inderide Labetalol HCl (Trandate) Levatol Metoprolol tartrate (Lopresor) Nadolol (Corgard) Nebivolol (Bystolic) Normozide   |

TRICYCLIC ANTI-DEPRESSANTS: (need to be stopped for 48 prior to testing {**physicians’ decision and *not the Clinical Allergy Coordinator’ decision}*)**

Amitriptyline (Elavil)

Nortriptyline Perphenazine

Desipramine (Norpramin) Protriptyline (Vicactil)

Doxepin (Sinequan) Trimipramine (Surmontil)

Etrafon (Perphenazine & Amitriptyline) Tofranil (Imipramine)

Limbitrol (chlordiazepoxide & Amitriptyline)

Mirtazapine (tetracyclic antidepressant)

**Medications to be STOPPED before Testing**

The following medications must be **STOPPED** **prior to allergy testing**.

***Stop the following Antihistamines 1 week prior to testing:***

Alavert

Allegra (Fexofenadine)

Allegra-D (Fexofenadine & Pseudoephedrine)

Atarax (Hyroxyzine HCL)

Cetirizine

Claritin (Loratidine)

Claritin-D

Clarinex

Clarinex-D

Fexofenadine

Loratadine

Xyzal

Zyrtec

***Stop the following (antihistamine sprays or drops) 5 days prior to testing:***

Astelin (Azelastine) nasal spray

Astepro (Azelastine) nasal spray

Patanase (Olopatadine Hydrochloride) nasal spray

Dymista Aerosol, spray

Nasal Allergy Rinse (mediated)

Patanol (Olopatadine) eye drops

Optivar (Azelastine) eye drops

Also ***STOP TAKING*** over-the-counter allergy and cold medication such as Benadryl (diphenhydramine), Dimetapp, Tylenol PM, Excedrin PM, Advil PM, ZZZQuil and any cough suppressants containing antihistamines.

**H2 blockers** TAGAMET (Cimetidine), ZANTAC (Ranitidine) and PEPCID AC (Famotidine) can suppress a histamine reaction during skin testing. Therefore, when possible, these medications should be **discontinued for 48 hours prior to testing.**

You may continue to use your intranasal steroid spray such as Rhinocort, Flonase, Nasonex, and Nasacort. Asthma inhalers (inhaled steroids and bronchodilator’s) and leukotrienes antagonists (e.g., Singulair, Zyflo).

***If you have any questions regarding these instructions, please call the clinic.***

**Allergy Consent and**

**Financial Disclosure and Agreement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, would like to proceed with Immunotherapy at this time. After reviewing the result of my allergy skin test with my referring physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I am a candidate for allergy treatment.

I am fully aware that the quote of benefits and/or authorization that was given to me does not guarantee payment or verify eligibility. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service.

This program is custom to my allergy needs and cannot be used for/by anyone other than myself. I understand that my insurance will be billed for which I will be responsible. Upon completion of 1st year of immunotherapy, I agree to consult with my referring physician to discuss improvement of allergy symptoms and continuation of immunotherapy.

All allergy patients are required to check with their insurance company regarding eligibility for coverage for allergy testing and treatment. Some insurance companies require co-pays for allergy testing and injections. Please be aware that we are required to collect patient co-pays and deductibles at the time of service.

If you wish to call your insurance company to check on your coverage for allergy testing and treatment, please provide your insurance company with the following codes to verify coverage:

Testing codes: 95004 & 95024

Treatment codes: 95165 & 95117

CANCELLATION POLICY: Due to the extended appointment time reserved for allergy testing, we must be notified within 3 business days, or a $50 cancellation fee may be charged.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (for minors): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Communication Consent Form**

Dear patient,

Allergy Services of America, LLC is committed to finding new ways to improve the quality of care that we provide to our patients. Your feedback is key to our success, and we value your opinion.

ASA would like to use your feedback for training purposes with our providers and technicians at all our locations.

An example of this would be contacting you to complete a short questionnaire about the care you received during your visit to the clinic and from time to time we may send you information on allergies and available treatment options that are available to you. We respect your privacy, your email address along with your personal information will be kept confidential and never sold or used outside this organization.

 Please contact me Please do not contact me

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergy Testing Consent Form**

**PATIENT NAME:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize the physicians **West Texas Health** and the associated technicians of Allergy Services of America, LLC to perform skin prick and intradermal skin testing upon myself / my child for the detection of possible allergies.

I further consent to the performance of other additional procedures different from that now contemplated, whether or not arising from presently foreseen conditions, which my doctors or their assistants may consider necessary or advisable in the course of the procedure. I have been made aware of certain risks and complications that are associated with the allergy testing procedure and allergy treatment. These include but are not limited to hypotensive episodes (drop in blood pressure), worsening of allergic symptoms (runny nose, itchy eyes, hives) and in rare cases, anaphylactic reaction (severe allergic reaction) including possible death. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this procedure or treatment.

This document has been fully explained to me and I certify that I understand its contents and agree with the above.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Minors:**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient (for minors): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergy Immunotherapy Consent Form**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Immunotherapy, hypo sensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. 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 and vomiting; hives; swelling of lips, tongue, and airway; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal. **You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection.** If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications, have not had a fever greater than 100.4 in the last 24 hours, and/or not complaining of respiratory symptoms such as wheezing. If I (or patient) am, I have discussed the risks/benefits of doing so with my physician prescribing the immunotherapy.

If I refuse to wait the required 30 minutes and leave early, I understand that it is against medical advice and I will hold my treating physician, the Clinic and Allergy Services of America, LLC and their staff harmless and free of any liability.

I understand that any questions that I (or patient) may have regarding potential side effects of immunotherapy must be directed to the physician prescribing the immunotherapy. The opportunity has been provided for me to ask questions regarding potential side effects of immunotherapy and these 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 such reactions. I also agree that if I have an allergic reaction to the injections, the physician-in-charge has permission to treat said reaction. I agree to notify the physician prescribing the immunotherapy of any systemic injection reactions within 24 hours. I understand that the immunotherapy antigen will NOT be released to me under any circumstances.

This document has been fully explained to me and I certify that I understand its contents and agree with the above.  I authorize the fact with my signature that I am authorizing the office to bill for the administration of immunotherapy.

|  |  |
| --- | --- |
| **Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |
| **For Minors:** **Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| **Relationship to patient** **(for minors): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |
| **Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Informed Consent of Office Protocol**

If I decide to initiate immunotherapy, I have been informed that I must wait up to 30 minutes in the office after each injection. This is for my protection. If an anaphylactic reaction should occur from an injection, it will usually happen within 30 minutes and can occur even though a person has been on the same treatment for years.

I understand this and will not come in for an injection on a day when I cannot wait in the office for 30 minutes.

I am aware that I should not be exposed to heat or exercise 2 hours before and 2 hours after my immunotherapy shots.

I have been informed that I will be asked the following questions at each of my clinic visits and any unfavorable answer(s) could delay my immunotherapy treatment:

1.     Have you had an increase in allergy or asthma symptoms over the past week?

2.     Do you have a fever, cold, flu-like or respiratory symptoms?

3.     Did you have any symptoms within 12 hours of your last shot received?

4.     Are you taking any new medications (including eye drops)?

5.     Have you been exposed to heat or have exercised within the past 2 hours?

6.     Are you pregnant?

7.     Do you have any new medical condition(s)?

8.     Do you have your EpiPen with you?

I have also been informed of my obligations with respect to referrals, co-payments and other insurance related issues for which I am responsible.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Consent for Medical Photography**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check here if minor or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for brochures, ASA Web Site or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact:

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

I consent for these photographs to be used in brochures, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientist and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Witness

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to the use of my child’s images as outlined above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature Witness

**HIPAA PRIVACY**

**AUTHORIZATION FOR USE AND DISCLOSURE OF**

**PERSONAL HEALTH INFORMATION**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as “HIPAA”).

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Allergy Services of America, LLC (“Covered Entity”) will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable,on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you acknowledge and agree that Covered Entitymay use or disclose \_Allergy testing results and treatment information\_\_\_ [describe information]for the purpose(s) of \_continuing care \_ [describe intended use].

By signing this authorization, you agree that Covered Entity or its Business Associatesmay disclose your personal health care information to West Texas Health [identify intended recipients].

 Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity’sHIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entityhas reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 501 Eastowne Drive, Suite 210, Chapel Hill, NC 27514. [Covered Entity’s address].

 In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entityfor as long as the PHI is maintained in the designated record set.

 You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entityhas taken action in reliance on it. A revocation is effective upon receipt by Covered Entityof a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

 This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion ofCovered Entity, or (d) six years from the date this authorization was executed.

 By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [name of patient] with a copy of this signed authorization.

[Continued on next page]

Acknowledged and agreed to by:

 PATIENT:

|  |  |
| --- | --- |
| By Print Name Address:   or, ON BEHALF OF PATIENTBy Print Name As Address:    |  Date Date |