RALEIGH CAPITOL
EAR, NOSE & THROAT

**PATIENT NAME: ________________________ DATE OF BIRTH: __________ TODAY'S DATE: _________**

## Allergen Immunotherapy Patient Consent Form

Immunotherapy (allergy shots) should be given at a medical facility with a doctor present since reactions may require immediate treatment. These may include: itchy eyes, nose, or throat; a stuffy or runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness or feeling faint; nausea and vomiting; hives; general itching; and, rarely, shock. Reactions are not typical, but they can be serious and, rarely, fatal. You are required to wait in the facility for **30 minutes after each shot**. For patients ages 17 or younger, a parent or legal guardian must be present during the waiting period.

I verify that I (or the patient) am not taking beta blockers or if I am, I have discussed the risks and benefits of getting immunotherapy with my doctor (see information sheet).

I have read (if a new patient) or re-read (if an established patient) the patient information sheet on immunotherapy, and I understand it. Although studies have shown that immunotherapy works for some patients with allergies, I understand that no guarantee has been made that this therapy will cure or resolve my symptoms.

I understand that allergy immunotherapy does not take the place of avoiding allergens that I am allergic (sensitized) to. I understand that the effectiveness of my treatment program depends on following recommendations about environmental controls and use of drugs.

I understand that if I keep getting allergy shots, I must be assessed from time to time to determine if the therapy should be continued or changed.

If allergy shots are received outside of this office, the person giving the shots has full responsibility for any side effects or adverse reactions.

I have had the chance to ask questions about the potential side effects of immunotherapy. These questions have been answered to my satisfaction. I understand that every precaution will be taken to protect me against such reactions. I also agree that if I have an allergic reaction, the doctor in charge has permission to treat me.

By signing this form, I authorize the office to bill for allergen vaccines after they have been made, even if I decide not to get immunotherapy. The vaccines will be mixed in the doctor's office before each appointment. sometimes several weeks in advance. Your insurance company (or you, if you are self-paying) will be billed for the total number of doses made. This charge is billed only when vaccines are prepared. It is separate from the charge for each shot. I agree to obtain prior authorization, if needed, from my insurance plan.

*Special Note: We cannot make any exceptions to the billing policy once this consent is signed.*

Patient's Consent: I have read and fully understand this consent form. I agree to be treated with allergy shots. I agree that I should not sign this form if I do not understand any part of it or if my questions have not been answered fully.

______________________________ ______________________________ **DATE** ____________
***PRINT NAME OF PATIENT*** ***PATIENT SIGNATURE***

______________________________ ______________________________ **DATE** ____________
***PRINT NAME PARENT OR LEGAL GUARDIAN*** ***PARENT OR LEGAL GUARDIAN SIGNATURE***

***As parent or legal guardian, I understand that I must stay with my child for the entire 30-minute wait.***

**WITNESS**____________________________________ **DATE**______________

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