ALLERGY TESTING/IMMUNOTHERAPY PATIENT CONSENT FORM

Miramont Family Medicine
Healthcare for Your Family from the Heart

Immunotherapy, hyposensitization, or allergy injections (to include allergy testing) 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 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; 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 20 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 or that if I am, I have discussed the risks/benefits of doing so with my physician.

I have read (if a new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the 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 that the physician-in-charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared up to 3 ½ weeks prior to my appointment. I agree to obtain prior authorization, if needed from my insurance plan. I understand that if my insurance company does not pay for the services provided, then I will be responsible for the balance due.

Patient_____ Date Signed_____

Parent or Legal Guardian_____ Date Signed_____
As parent or legal guardian, I understand that I must accompany my child throughout the entire 30 minute wait.

Witness_____ Date Signed_____