THIS FORM MUST BE RETURNED
TO OUR OFFICE TO INITIATE ALLERGY IMMUNOTHERAPY

Date: ____________________

Patient: ____

Date of birth: _____________________

MEDICAL ARTS ALLERGY, P.C.

Jack L. Armstrong M.D.

Donald S. Harper M.D. **Helen C. Wang M.D.**

Miae Oh, M.D. **Jodi L. Johnson C.R.N.P.**

AMERICAN BOARD OF ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

Medical Arts Building
220 Wilson Street, Suite 200
Carlisle, PA 17013
(717) 243-7540 Fax: (717) 243-9968

Fredricksen Outpatient Center
2025 Technology Parkway, Suite 310
Mechanicsburg, PA 17050
(717) 791-2640 Fax: (717) 791-2646

Bloom Outpatient Building
4310 Londonderry Road, Suite 201
Harrisburg, PA 17109
(717) 920-4340 Fax: (717) 920-4341

Serum Preparation Consent

I have read and understand the patient information packet provided to me on immunotherapy. The opportunity has been provided to me to ask questions and they have been answered to my satisfaction.

I acknowledge the fact, with my signature that I am authorizing Medical Arts Allergy to prepare and bill for the allergy serum, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine is made.

I have checked with my insurance carrier and understand that even though this may be a covered service, the fee to prepare the serum and the fee to administer the serum are subject to my deductible and my co-insurance. I understand out-of-pocket expenses may be incurred if I have not yet met my deductible or my co-insurance.

Signature:

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New Start Yes ◯ No ◯

Ordering Doctor: ______________________

If Doctor discussed Rush Therapy with you, do you wish to proceed with Rush Therapy?

Yes ◯ **No** ◯

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