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MEDICAL ARTS ALLERGY, PC

Your family's specialists in Asthma, Allergy and Immunology
www.medicalartsallergy.com

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

Date: _____

Patient: _____ **Date of birth:** _____

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.

Please **circle** the location where you will be getting your injections: **Carlisle** **Mechanicsburg** **Harrisburg**

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

Yes ⬭ **No** ⬭ **(Rush is not covered by Medicare and Medicare Advantage plans)**

Signature: _____

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Office Use Only:

New Start Yes ⬭ No ⬭
Ordering Doctor: _____

- ☐ Insurance Verified
  - ☐ PEBTF and Payment Forms Completed
  - ☐ Tricare Prime–Request additional units = 1/3 vials (CPT Code 95165)
- ☐ Chart Note Done
  - Routed to Provider and Lou (New Starts Only)

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Suite 200
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