ALLERGY, ASTHMA, AND IMMUNOLOGY INNOVATIONS

Neha Yakhmi, MD
Kokomo: 2216 W. Alto Road, Kokomo, IN 46902
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Allergen Immunotherapy Consent

I (patient or parent, legal guardian, or power of attorney who is executing this Consent Form on the patient's behalf) hereby consent to the performance of allergen immunotherapy injections (allergy shots or injections).

1. Background Information: I have read the "Immunotherapy (Allergy Shots) Background Information for Patients" handout on immunotherapy and understand it, including the nature of my condition, the proposed treatment, expected outcomes, material risks and side effects of immunotherapy, as well as the potential alternatives to immunotherapy. I have had the opportunity to ask questions regarding immunotherapy and my questions have been answered to my satisfaction.

2. Reactions: 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.

3. Billing/Prior Authorization: I acknowledge that I am authorizing the office to bill for allergy shots, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the injection has been made. The allergen extract will be mixed in the physician's office under the appropriate standards and will be prepared in advance (potentially several weeks) of my appointment. I agree to obtain prior authorization, if needed, from my insurance plan.

4. Administration Site: I elect to have my allergen immunotherapy injections given at the following location:

_____

_____

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5. Patients Under Age 18: I understand if the patient is 17 years of age or younger, I (parent or legal guardian) must be present during the thirty (30) minute waiting period after the injection.

6. Medications/Beta Blockers: I verify that I am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician (see "Immunotherapy (Allergy Shots) Background Information for Patients" handout).

7. Pregnancy: If I am to become pregnant during my time on immunotherapy, I will inform the office immediately. I understand that if I have been on immunotherapy for less than one year, my injections will likely be stopped. I understand that while pregnant, my immunotherapy dose kept the same and not increased.

8. Contents and Withdrawal: I understand the contents of this consent form. I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction. I understand that I can withdraw this consent at any time.

Patient Name: _____ DOB: _____

Parent/Guardian: _____

Signature: _____ Date: _____

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