ALLERGY, ASTHMA, AND IMMUNOLOGY INNOVATIONS

I (patient or parent/legal guardian) agree that by signing this, I am giving my consent for new vials of my allergy extracts to be made. I am aware that the cost of my allergy extract vials will be billed to my insurance on file and I will be responsible for the remaining amount.

Patient name and DOB:_____

Signature: _____ Date:_____

- ☐ Patient
- ☐ Parent/ Legal Guardian

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