Allergy & Asthma Center
of Southern Oregon, PC
Edward M. Kerwin, MD Kevin W. Parks, MD Ryan B. Israelsen, MD
Kary A. Kelly, FNP-C Tiffany R. Smith, PA-C
Phone (541) 858-1003 Fax (541) 857-4499

IMMUNOTHERAPY CONSENT FORM

Dr. Kerwin/Dr. Parks/Dr. Israelsen has recommended Immunotherapy (allergy shots) as a form of treatment for you or your child. It is important for you to understand the purpose and expectations of allergy shots, the general program (schedule), the risks of allergy shots and alternate treatment options.

The purpose of Immunotherapy is to make the patient less sensitive to one or more specific allergens (pollens, dust mites, molds, animals, bee venom, etc.). Immunotherapy is often considered if allergic symptoms are not controlled by other measures, if medications are causing side effects or if your symptoms require prolonged use of medication.

An extract is prepared according to a patient's specific sensitivities and may be given only to that individual patient. Injections are given at weekly or bi-weekly intervals in gradually increasing doses. When the highest dose (maintenance dose) is reached the shots may be gradually lengthened to a monthly schedule. It usually takes 5-8 months to reach maintenance dose. The total duration of Immunotherapy is usually 3-5 years.

The reduction in sensitivity is not seen immediately and often takes a year to be apparent. The majority (80% or more) of patients note significant, but not complete reduction, in allergic symptoms and still need to keep exposure to allergens as low as possible and may need to take medications. In this circumstance, medicines tend to be more effective than before Immunotherapy and are needed for shorter periods of time. A smaller percentage note nearly complete control of allergy symptoms with Immunotherapy. A small percentage find Immunotherapy does not change their symptoms appreciable and the injections are stopped if this is the case. Your probability of improvement can often be estimated by your history and allergy evaluation. We consider the role of Immunotherapy in the treatment of allergic disease to be an adjunct not a substitute for other measures such as allergen avoidance and medications.

It is possible to have a systemic reaction to allergy shots. These usually occur within minutes after an injection (but may rarely occur up to several hours later) and are easily treated, but require immediate attention. The reactions may involve itching, rash or swelling in places other than the injection site, hay fever symptoms, trouble breathing, and faintness due to dropping blood pressure. These reactions are very rare and usually reverse quickly if treated, but have the potential of being serious and even fatal. Therefore, you must receive allergy injections in a physician's office. You must wait the designated time period after your injection (usually 20-30 minutes) and you should notify the nurse if you notice any of the above symptoms.

You should not receive your allergy injection if you have a fever. You should notify the nurse if you are having a flare-up of asthma or hives. You should avoid strenuous exercise for two hours after your shot. You should notify us of all new medications you are taking. You cannot take allergy shots if you are taking BETA BLOCKER medications (used for blood pressure and heart problems, migraines or as an eye drop for glaucoma).

Local reactions are common after allergy shots and consist of redness, swelling and itching. These may be immediate or delayed in onset and may last hours to a day or more. If local reactions are excessive report the reaction to the shot nurse before your next injection.

Allergy shots may be given in pregnancy. Please notify us if you are pregnant as minor changes in your shot program may be needed and we should review your overall allergy management program.

Please notify us if any questions or concerns arise during the course of your Immunotherapy program.

Check box if applicable:

☐ I understand that getting allergy shots while on Beta Blockers could moderately increase the risks of allergy shots or make treatment of shot reactions more difficult, but I would still like to try allergy shots, while continuing my Beta Blocker.
Pt. Initial: _____ Date:_____

I, the undersigned, have read the above information and wish to proceed with allergy Immunotherapy treatment. I understand that by signing this form that I am giving my permission for the antigens to be mixed and billed to my insurance. I also understand that I am responsible for payment of the extracts once this form is signed.

I have read and understand this statement: Pt. Initial _____ Date _____ Staff Initial_____

_____	_____	_____	_____
(Patient Name Printed)	**(Parent or Legal Guardian Name)**	**(Patient DOB)**	**(Patient ID#)**

_____	_____
(Patient/Parent or Legal Guardian Signature)	**(Today's Date)**

_____	_____	_____
(Witness Name Printed)	**(Witness Signature)**	**(Today's Date)**

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Financial Responsibility Agreement for an Allergy Serum Mix

Most Health Insurances will cover Allergy Serum Mixes. Our office cooperates with your insurance to get you the best serum pricing negotiated by your insurance.

Many Health Insurance policies require that an annual deductible be met before they pay for medical services. If you are not sure how your Insurance will process a Serum Mix, please contact the billing department and they will help you with any questions.

While receiving Allergy Injections, if your insurance applies a high deductible, or a co-payment for each visit, then monthly payments MUST be made toward your balance.

Before your Allergy Serum can be re-mixed when it expires after a year's time, the current Allergy Serum needs to be paid in full, and your account balance should not be over $200. If these requirements are not met you will not be able to get an Allergy Serum Re-Mix in order to continue your Immunotherapy.

Our medical office and staff are providing a service to you. Payment in a timely manner is required for our services.

By signing below, I understand that payments that are not covered by insurance may be required at time of service as described above.

Signature of Patient Patient Name DOB Date

(if minor patient) Signature Parent/Guardian Name Parent/Guardian Date

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Allergy Shot Information and Consent to Notify

I. You have signed a consent form for allergy shots. The allergy shot treatment sets are made up in the Medford office and take about 6-8 weeks to prepare. If you do not hear from the Medford office in 6 weeks please feel free to call (541) 858-1003 and check on the status of your allergy shots.

II. Be sure to take an antihistamine on shot days, even if your allergy symptoms are controlled.

III. Wear clothing that allows easy access to the injection site, which is the upper arm area.

IV. It is required that you wait for 20 minutes after an allergy shot or 30 minutes after a venom shot. If you cannot wait the required time your shot will not be given. Also allow extra time when starting shots for instruction time.

V. Take food and fluids on shot days, do not fast.

VI. Avoid getting an allergy shot if you are acutely ill with a cold, flu, fever or untreated infection. If being treated with an antibiotic for a condition, you must be on the antibiotic 72 hours to get an allergy shot.

Patient Name: _____ DOB: _____

Once my serum has been made please notify me via (please check one):

□ **Mailing Address: _____**
Street City State Zip Code

□ **Email: _____**
(please print clearly)

□ **Patient Portal.** Patient Portal invitation is sent via Email or you can request access at **http://allergyasthmaso.myezyacces.com Invitation Email:_____**

Patient Acceptance of E-Mail Risks

I request that this practice communicate my Protected Health Information (PHI) via in an e-mail message that is not encrypted or otherwise secured. I am aware that my health information will be sent over an unsecured network and could be intercepted and used for identity theft purposes. I hereby accept those risks and absolve the Allergy & Asthma Center of any liability for these E-mail transmissions.

_____ _____
(signature) (or signature of legal representative)

_____
(Date)