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

Remix Authorization Form

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

wish to continue with my/my child's allergy immunotherapy program and hereby authorize Allergy & Asthma Center to re-mix my/my child's allergy extract(s). I understand that I need to provide Allergy & Asthma Center with a current copy of my/my child's insurance card at the time I sign this authorization. If I do not have the insurance card in my possession at the time of signing, I understand that I will be responsible for payment of the extract(s) if the insurance information on file with Allergy & Asthma Center is incorrect or invalid.

I have read, understand and agree to the above statement:

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

_____ _____
(Shot Nurse/MA Signature as Witness) **(Today's Date)**

_____ _____
(Signature of MD Overseeing Immunotherapy) **(Today's Date)**
Dr. Kerwin / Dr. Parks / Dr. Israelsen

Last Injection:

DATE	VIAL (A/B/C)	CONC.	AMOUNT	GIVEN BY	Reason for Remix

Office where shots are given: **MEDFORD** **GRANTS PASS** **KFALLS** **RB**
(please circle correct office)

ASHLAND **OUTSIDE OFFICE: _____**

***PLEASE ATTACH A COPY OF PATIENT'S <u>CURRENT INSURANCE CARD</u>**

Checklist and Approval for Remix of Allergy Serum

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

_____ _____ _____
(Patient Name) **(Patient DOB)** **(Patient ID#)**

Date Remix Auth. Signed: _____ **Date Patient Started Immunotherapy: _____**

Steps 1-3 to be completed by Shot MA with patient:

1. **Current Medication Use: (mark all)**
   - ☐ Medication use for optimal control discussed with patient
   - ☐ Frequency of shots? Circle one: Q weekly Q 2 weeks Q monthly Other
   - ☐ Which antihistamines are used on shot days? _____
2. **Reactions to Injections: (mark one)**
   - ☐ No significant reactions
   - ☐ Local reactions (dime sized swelling or larger) in the past month
   - ☐ Systemic reactions (needed Epinephrine in the last year)
   - ☐ Other: _____
3. **Patient's Response to Immunotherapy: (mark all that apply)**
   - ☐ Much better- nose allergies- occasional antihistamines
   - ☐ Much better- asthma symptoms 2 days weekly or less
   - ☐ Much better- skin eczema rash infrequent (<1 time monthly)
   - ☐ Allergy symptoms remain active
   - ☐ Allergy symptoms unchanged
   - ☐ Worst Seasonal Symptoms: Circle: Spring Summer Fall Winter

MD Steps 4-7 to be completed by AAC medical doctor overseeing immunotherapy:

4. **Antigen Content of Vials: (mark all that apply)**
   - ☐ Antigen mix is still optimal for current medical status
   - ☐ Antigen content of vials needs to be adjusted (optional)
   - ☐ Other: _____
5. **Injections are: (mark one)**
   - ☐ Continued as patient getting ongoing symptom improvement
   - ☐ Patient okay to graduate (>4-5 years immunotherapy done)
   - ☐ Patient needs long term immunotherapy (>5 years) marked ongoing symptoms and ongoing marked exposure
   - ☐ Patient needs allergy reevaluation
   - ☐ Other: _____
6. ☐ **I have considered all of these in making the decision to continue immunotherapy.**
7. ☐ **Medical doctor overseeing patient needs to sign Remix Authorization Form on next page.**

_____ _____
(Signature of Medical Doctor Overseeing Immunotherapy) **(Today's Date)**
Dr. Kerwin / Dr. Parks / Dr. Israelsen

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

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

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

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)