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I the undersigned give my authorization to treat and assign directly to Asthma & Allergy Medical Care, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.															
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ASTHMA & ALLERGY MEDICAL CARE, PC FINANCIAL AGREEMENT

We appreciate the confidence that you have expressed in selecting us as your physicians. If you have any questions regarding our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

A payment for your office visit is required at the time of service for:

- Patients without insurance
- Patients with private insurance
- Patients who are not covered by one of our contracted insurance plans. (PPO, HMO, EPO, POS, MC)
- Patients who do not provide us with contracted insurance information

For Medicare and contracted insurances, we will bill all services at no charge as per the requirements of the insurance contract.

All monies owed by the patient (co-pays, deductibles and non-covered services) are payable at the time of the service. For patients with contracted insurance policies, all co-pays and deductibles are to paid each and every visit. Patients with private insurance or no insurance are required to pay on their account each and every visit.

Any patient that is seen or treated in our office, without prior authorization from their contracted group, is responsible for the full charge of the visit.

Patients will be responsible for obtaining appropriate physician referrals before their scheduled office visit, otherwise, payment in full will be required at the time of the service.

If you need to use a specific lab or x-ray facility, you must notify the nurse before the service is rendered.

Any service that is rendered by this office, that is not a covered benefit of your insurance policy, is your responsibility to pay.

It is your responsibility to inform the office staff of any changes with your insurance coverage.

Our staff will assist you in dealing with your insurance company, but it is your responsibility to know and understand your own insurance policy.

It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date.

I have read and understood the above information.

Signature	Date
(Patient/Parent/Guardian)	

Asthma & Allergy Medical Care, PC

CONSENT TO RECEIVE IMMUNOTHERAPY (ALLERGY SHOTS)

Immunotherapy (allergy shots) is a treatment used to relieve allergy symptoms of hay fever or allergic asthma by administering injections of substances such as pollens, mold spores, house dust mites, or animal danders to which an individual has been found to be allergic by skin testing or a positive blood test (RAST). Allergy injections have been shown to lead to the formation of blocking or protective antibodies. These changes may permit you to tolerate exposure to the allergens with fewer symptoms. The amount of this immunization occurs to a different extent for each person.

Allergy shots are administered only to allergic patients who have severe symptoms not controlled by environmental control measures or medications, or which persist and require daily medications.

Improvement should not be expected immediately. It usually requires 4-6 months before any relief of allergy symptoms is noticed and it may take 12 months for the full benefits to occur. About 80% of allergic individuals on immunotherapy get significant improvement of their symptoms.

Allergy injections are usually begun at a very low dose. This dose is gradually increased on a weekly basis until a "maintenance dose" is reached. This frequency reduces the chances of a reaction. The goal is to eventually spread the shots to every 4 weeks for a period of 3-5 years. It is important that the recommended schedule be followed. Allergy injections may be discontinued if visits are frequently missed because there is an increased risk of reactions under those circumstances.

Local reactions (swelling, itching or tenderness at the site of the injection) may occur in most patients receiving injections. These local reactions usually subside in a day or less. Large local and generalized (systemic) reactions may occur in a small percentage of patients receiving allergy injections and usually occur during the build up phase, although they may occur at any time during the course of treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose or throat, runny nose, nasal congestion, sneezing, tightness in the throat or chest, coughing wheezing. Also, some may experience lightheadedness, faintness, nausea and vomiting, hives, and, under extreme conditions, shock.

It is the responsibility of each patient to:

- 1. remain in the office under observation for at least 20-30 minutes following their allergy injections.
- 2. notify the medical staff of Asthma & Allergy Medical Care, PC prior to receiving any injection(s) if you are experiencing fever, chest tightness, wheezing, shortness of breath, or chest pain.
- 3. notify the medical staff if you are taking any beta-blocker medication for treatment of any medical condition.

Asthma & Allergy Medical Care, PC

CONSENT TO RECEIVE IMMUNOTHERAPY (ALLERGY SHOTS)

I have read the patient information letter regarding immunotherapy (allergy shots) on the preceding page. Professional supervision will be present during the administration of my treatment and the observation thereafter for appropriate precautionary measures as well as treatment should it become necessary.

In the event of an adverse reaction, I authorize and accept responsibility for appropriate treatment as directed by Asthma & Allergy Medical Care, PC.

I understand that as of this date the available information indicates that treatment must continue for a period of 3-5 years to be maximally effective.

I have read this document and understand its contents. I have been given the opportunity to ask questions.

With knowledge of the above information, I hereby choose the begin treatment for my condition.

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patient's signature	date