Illinois Allergy & Asthma Specialists

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INFORMED CONSENT FOR IMMUNOTHERAPY (ALLERGY SHOTS)

Introduction-Skin testing has confirmed that you have an allergic response to one or more substances known as allergens (for example: pollens, molds, dust, etc.). Allergy shots (small amounts of allergens) given on a regular basis over several years may reduce your symptoms when you are exposed to allergens. These shots should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy.

Payment/BILLING-Each patient's allergy material is individually prepared based on his/her own allergic sensitivities, so no other patient may use it. Therefore, it is our policy to charge the insurance company/patient in advance for all allergy material upon its preparation. When asking for coverage, please ask about the following codes:

- 95165- allergy serum (this is the largest upfront cost the first year)
- 95117- billing for two or more injections
- 95115- billing for one injection.
- BILLING: Depending on how many injections you receive, for the first billing cycle, you will be billed as follows **(this is due to insurance coverage issues):**
    - 50 units (this will be billed all at once)-if you get just one injection
    - 100 units (this will be divided over the course of 4-6 months)-if you get 2 injections
    - 150 units (this will be divided over the course of 6-9 months) -if you get 3 injections
- I understand that I am responsible for any amount not covered by my insurance (i.e., plan exclusion, no referral on file, out of network, coverage terminated, high deductible, etc.)

Instructions-It is important that you understand the information in this consent form for you or your child (<17 years old), referred to collectively as "I" moving forward. Please talk with your doctor about your concerns. Ask your doctor to answer your questions. When you feel you understand the information that your doctor and this form have provided, please sign the bottom of this page.

1. **I allow** Drs. ___Chou/Murthy_____(my physician) and assistants as may be selected to give me Allergy Shots.
2. **I understand** that at the start of my treatment (the "build up" phase) I will receive injections once or twice a week for a period of months-usually four to ten. The dose of allergen will be increased slowly until a maintenance dose is reached. Then the injections will be given every two to four weeks for a period of several years. The injections will be given with a very small needle. **I understand** that following my allergy shot, I must remain in the office for **30 minutes** so that I can be treated quickly in case I have a systemic reaction. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period.
3. **I understand** that I may experience a local reaction, such as swelling, itching, or tenderness at the site of the injection. This usually lasts a day or less. **I understand** that although uncommon, a systemic reaction may include any or all of the following: itchy eyes, nose, or throat; runny nose; nasal congestion; sneezing; nausea; vomiting; hives; tightness in the throat or chest; coughing; wheezing; difficulty breathing; lightheadedness; faintness; unconsciousness. **I understand** that reactions can be serious but rarely result in death. **I understand** that if I frequently miss my injections, my risk of a reaction during therapy increases. **I understand** that my physician may lower my highest, or cap dose if I have large local reactions or other reactions. **I understand** there is a small chance that allergy shots may not be effective. **I understand** that if treatment is effective, it will likely take 6-12 months before I notice any reduction in my allergy symptoms and approximately 3-5 years before I obtain full benefit from the treatment. **I freely accept** these risks.
4. **I understand** this treatment is suggested to relieve my discomfort from allergy symptoms. **I understand** that I must have a physician appointment each time I start injections from a new vial and at minimum once a year. My physician may discontinue my allergy shots at any time if he/she believes that the benefits of allergy shots do not sufficiently outweigh the risks.
5. **I understand** that I can decide not to have this treatment now or at any time in the future.

MRN: _____

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6. **I understand** that anecdotal evidence has shown that biking to my appointment can prime my immune system for an allergic reaction and I will not bike to and from my appointment, and that I should refrain from cardio exercise for 2 hours before and after my shot.
7. **I consent** to treatment of a local or systemic reaction occurring as a result of the allergy shots. **I understand** that the agents used to treat the reaction involve a certain amount of risk and the possibility of complications.
8. **I understand** that unexpected reactions or interruptions in my injection schedule may result in the delay of my schedule and lead to the expiration of certain vials before they are used completely, requiring them to be remixed with additional charges added to my account.
9. **I understand** that I should not be on a beta-blocker medication (used for high blood pressure, migraine headaches, anxiety/panic attacks, and glaucoma (eye drops)) while on immunotherapy because it can potentially render treatment ineffective, should a severe allergic reaction occur.
10. **I understand** that I should inform the doctor and staff if/when I become pregnant, because my dose of immunotherapy will need to be altered.
11. **I understand** that my physician will bill my insurance company or myself prior to my starting allergy shots. **I understand** that if I agree to have serum made and do NOT show up to my allergy shot appointments, I will be responsible for the cost not paid by my insurance plan, which is $750 for one vial and $1500 for two vials of serum for one year.
12. **I have made** my decision freely and voluntarily, and all questions have been answered.

_____ _____
Patient Signature Date

_____
Patient Name (PRINTED)

Dr. Chou/ Dr. Murthy_____
Physician Signature

As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait.
_____Initial

MRN: _____