

ALLERGY & ASTHMA ASSOCIATES

Richard C. Loria, M.D.

Courtney J. Blair, M.D.

Penny Flores, FNP

ALLERGY SERUM RENEWAL CONSENT FORM

(for patients receiving their shots in our office)

Patient Name: _____ **Date of Birth:** _____

Date of Request: _____

I authorize Allergy and Asthma Assoc. to prepare:

_____ a dilution of my extracts (insurance may not cover dilutions)

_____ fresh extracts (when serum is expiring or running low)

I receive my shots in the Mclean Office _____ Sterling Office _____

My current insurance is: _____

My policy number is: _____ My group number is: _____

An insurance referral (preauthorization):

NOTE: If neither box is checked we will assume no referral is required!

_____ **is required** and I understand that it is my responsibility to obtain one for serum construction and fax/send it to the lab in the Sterling office before serum can be made.

_____ **is not required. If my insurance determines a referral was required and payment is denied, I will be responsible for the cost of the serum.**

I understand that Allergy and Asthma Assoc. requires an annual office visit for all patients on allergy shots. If I have not had this visit, it will delay processing of my request for serum.

If Allergy and Asthma Assoc. participates with my insurance, there will be a charge billed to my insurance company for the new serum or any dilutions of serum. I will be billed for any remainder not paid by my insurance company (including my copay/cost share), less any contractual adjustments required.

If I do not have insurance or Allergy and Asthma Assoc. does not participate with my insurance, I understand that I will be required to pay **30%** of the cost of the extracts **at the time of delivery**. The lab will supply me with a fee ticket which can be submitted to my insurance company. I will be responsible for paying for the **balance due in 60 days**.

I have read the above, agree to have new serum made, and will make payment as described. I understand that allergy serum may take 2 - 3 weeks to prepare and if the insurance information provided above is not correct or changes before my serum is prepared, I will be responsible for payment in full for my allergy serum. I understand that if I elect to stop receiving allergy shots, any remaining serum will not be credited, since it was made specifically for me and cannot be used for any other patient. If I leave the practice for any reason, I will be permitted to take any remaining serum provided I follow the take-out procedures of the practice and no further serum will be provided by Allergy and Asthma Assoc. after the expiration date of the serum.

Signature of Patient or Guardian

Date