

ALLERGY & ASTHMA ASSOCIATES

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ALLERGY SERUM RENEWAL CONSENT FORM

(for patients receiving their shots at another location)

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 at: _____

I will have a **current copy of my allergy shot record faxed to the lab.** (703-430-6073)

Please check one:

___ **I will pick up my serum in** ___ **Mclean** ___ **Sterling** and I understand there is a \$10 charge for packing the serum.

___ **I wish to have my serum mailed** and I understand the charges are **\$20 plus the FEDEX overnight fees** and I agree to pay for this service. [Requirements for both options are explained on the second page of this form.]

My current insurance is: _____

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

My insurance **requires a referral** (preauthorization):

Please check one!

___ **Yes** 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.

___ **No. If my insurance determines a referral was required and payment is denied, I will be responsible for the cost of the serum.**

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

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

Patient Information: (do not return this page)

Pick-Up Option for serum: Patients will be allowed to pick up their serum if it can be delivered to the administering physician's office within a three hour time frame. The serum will be specially packed and there will be a \$10 transfer fee for this service. This fee cannot be billed to the insurance company and payment must be made before serum is released. **All pick-ups must be scheduled as a nurse visit. We will not be able to do walk-in pick-ups.**

Mailing option for serum: If serum cannot be delivered with a 3 hour time frame, the serum must be mailed to the administering office. **There will be a fee of \$20 plus the Fed Ex Express (overnight) charges.** These charges cannot be charged to insurance and will be billed to your account. We can no longer do Fed Ex Ground for local shipping.

If you have any questions, please call the serum lab at 703-430-0833 ext. 19.