Allergy Asthma Food Allergy
CENTERS
FREEDOM FROM YOUR ALLERGIES

Immunotherapy Financial Consent Authorization

Insurance plans are highly variable regarding coverage of immunotherapy treatment. There are two costs to consider when receiving immunotherapy. The first cost is for the “antigen” or “extract” (95165). The antigen is prepared from a formula that your physician has written specifically for you based on what you are allergic to. The second cost is for the administration of the injections (95115 or 95117- depending on how many injections you receive; or 95180 if you choose cluster immunotherapy to more quickly reach the target dose for more rapid improvement in symptoms).

It is important to understand your insurance coverage and know your out-of-pocket expenses. Some insurance plans cover immunotherapy, in full, while other insurance plans have associated deductibles, coinsurance, limitations and copays. We assist with your insurance verification by providing you with an estimate of benefits and an estimated out- of-pocket cost but we highly recommend you contact your insurance carrier to determine your specific coverage.

I have discussed my insurance and payment information with the staff at Allergy, Asthma & Food Allergies Centers regarding the charges for allergy extract and injections. I authorize Allergy, Asthma & Food Allergy Centers to order and prepare my allergy extract. I understand my account will be charged and insurance filed for the serum and preparation for these vials.

I further understand that the allergy extract is specifically prepared for me and I am financially responsible for these charges. If I decide to discontinue my immunotherapy, I will still be responsible for these charges. I understand that my insurance plan may not cover any discarded allergy extract. I am aware that unexpected reactions or interruptions in my injection schedule may result in the expiration of prepared vials and I will need new vials prepared, which will result in an additional charge.

With this acknowledgement, I request my vials to be prepared and I consent to any necessary treatment required in the event of an injection reaction.

_____ _____/_____/_____
Patient Name (Print) Date of Birth

_____ _____/_____/_____
Signature of Responsible Party Date of Signature

South County: 9701 Landmark Parkway, Suite 207, St. Louis, MO 63127 Ph: 314-849-8700 Fax: 314-849-8737
West County: 16216 Baxter Road, Suite 299, Chesterfield, MO 63017 Ph: 636-536-2600 Fax: 314-849-8737
Ste. Genevieve: 255 Boderman Lane, Bloomsdale, MO 63267 Ph: 314-849-8700 Fax: 314-849-8737
Swansea: 510 Fullerton Road, Swansea, IL 62226 Ph: 618-233-8700 Fax: 314-849-8737
www.aafacenters.com