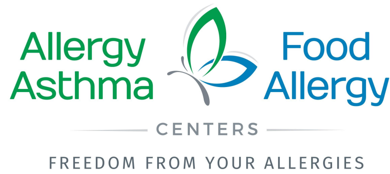

Allergen Immunotherapy Financial Consent Authorization

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 highly recommend you contact your insurance carrier to determine your specific coverage.

If you are not sure yet that you want to start allergy shots, please do not return the signed consent forms. ___ (Patient/Guardian Initials)

I have discussed my 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 extract 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/Guardian Initials)

I understand that once the practice has received these signed consent forms, the extract mixing process will begin, and a claim will be sent to my insurance company within 2 weeks to bill for the vials.

_______________________________________ _____/_____/_____

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
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