Virginia Ear, Nose & Throat

CONSENT FOR ADMINISTRATION OF CONVENTIONAL IMMUNOTHERAPY [SHOTS]

PLEASE READ, AND BE CERTAIN THAT YOU UNDERSTAND, THE FOLLOWING INFORMATION PRIOR TO SIGNING THIS CONSENT FOR TREATMENT

Patient's Name: _____ Patient #: _____

PURPOSE

The purpose of subcutaneous immunotherapy or allergy shots is to decrease your sensitivity to specific allergens (such as pollens, dust mites, animal danders and mold spores) that cannot be completely avoided and require chronic medication. Allergy shots have been shown to result in the formation of "blocking" or protective antibodies, and a gradual decrease in allergenic antibody levels. The end result of this change is that you become more "tolerant" of the offending allergen(s) with a significant reduction in symptoms. Immunotherapy is not effective for food allergy, chemical reactions or irritants such as cigarette smoke, odors or fumes.

INDICATIONS

It has been determined that you are a candidate for allergy shots. To qualify, you must have a documented allergy to an allergic substance. This may be documented through allergy skin testing or allergy blood testing. Additionally, you must be symptomatic with exposure. Due to the risks involved in immunotherapy, avoidance measures and medications are usually attempted first.

EFFECTIVENESS

Improvement with your allergy symptoms is not seen immediately and your allergies may in fact worsen initially while starting your allergy injections. Patients may not see improvement for 6-9 months and full benefits may not be evident for 12 months. The effectiveness is different in each person and therefore unpredictable. However, approximately 80-90% of allergic individuals who undergo allergy injections will see significant improvement.

PROCEDURE

The allergy shot is a mixture of the allergens to which you are allergic. When you begin receiving your allergy shot, the mixture is diluted so that your body will be less likely to react to the shot. Your allergens may need to be divided into more than one shot. The dose is increased regularly, once a week, until the full strength shot (maintenance dose) is achieved.

DURATION

The time it takes to reach your maintenance dose will vary, but usually takes 6-12months. Factors that influence the time it takes to reach your maintenance dose include the severity of your allergies, missed shots and any reactions to your shots. For this reason it is recommended that the immunotherapy schedule be followed and you are consistent with your therapy. If you anticipate that it will be difficult for you to get your shots on a routine basis, immunotherapy should not be started. Immunotherapy may be discontinued at the discretion of the doctor if the shots are frequently missed due to the increased risk of adverse reaction under these circumstances.

You will need to make a follow up appointment with the physician 3 months after you have started allergy shots to evaluate your progress. It is currently recommended that immunotherapy be continued for a period of 3-5 years. You will be required to been seen at least once a year while receiving treatment. However, your doctor will be monitoring your progress and will determine when and how often you need to be seen as well as the frequency of your shots. Once you have been tolerating maintenance for a period of time the doctor will determine your ability to come every other week. You will eventually work your way to shots once a month, as long as you continue to do well.

ADVERSE REACTIONS

There are two types of reactions that can occur after an allergy shot. The first, called a local reaction may include itching, redness and swelling at the site. Localized reactions may occur immediately or develop as much as several hours later. You must report any site reactions **PRIOR** to your next shot so your dose can be adjusted. The second type of reaction is a generalized, systemic or anaphylactic reaction. Systemic reactions are rare occurring in less than 1% of patients but are the most significant because they are potentially life threatening. Symptoms include hives, swelling of the face, coughing, wheezing, shortness of breath and difficulty breathing and may lead to anaphylactic shock.

OBSERVATION FOLLOWING INJECTIONS

The most likely time for an allergic reaction to occur is 15-20 minutes after receiving your shot. Patients receiving immunotherapy must wait 20 minutes after receiving their shot for observation. It is possible to have a delayed reaction up to several hours after receiving an allergy shot. For this reason you will be prescribed and required to bring an Epipen to each shot visit. You will also need to carry your Epipen for at least 24 hours after you have received your shot. Directions for when and how to use the Epipen will be reviewed at your first shot appointment.

PRECAUTIONS

Patients receiving immunotherapy should not use beta-blocker medications used to treat high blood pressure, glaucoma and migraines as it is contraindicated and could have dire consequences. Your injections may need to be re-evaluated and/or discontinued if you are taking these medications.
For your safety, you should report any new prescription medications to the allergy nurse/doctor immediately in order to avoid any possible adverse reactions.

Females of child bearing potential: Please notify the allergy nurse/doctor immediately if you become pregnant. Immunotherapy does not have to be discontinued. However, for safety, your doses will not be advanced during pregnancy. If you have not reached maintenance, your shots will remain at the current dose until you deliver, at which point we will resume advancing your shots.

PAYMENT OBLIGATION

It is important for you to understand that we cannot guarantee payment from your insurance company. As a patient, you are obligated and responsible for full payment of your extracts and injections. We will file a claim with your insurance provider. After the second or third visit we will be able to determine what your coinsurance amount for your extracts and injections will be. You will be informed of these amounts. Payment will be collected when you check in before receiving your shot. You will be required to give at least 2 weeks' written notice of your intent to discontinue immunotherapy.

Virginia Ear, Nose & Throat

CONSENT FOR SUBCUTANEOUS IMMUNOTHERAPY [ALLERGY SHOTS]

Patient's Name: _____Patient #: _____

Please initial the following:

_____ I confirm that I (patient) am not taking beta-blocker medications. I will inform the physician and/or allergy nurse of any changes in my medical condition (including pregnancy for women) or changes in my medications.

_____ I have read the patient information sheet on allergy immunotherapy in this consent form and understand it.

_____ The risks involved in undergoing allergy treatment have been satisfactorily explained to me, including the possibility of local reactions to the injections, increased allergy symptoms (e.g., increased congestion, rhinorrhea, itchy eyes, tearing eyes, flushing, itching, asthma), and rarely severe anaphylaxis resulting in respiratory distress and/or death.

_____ I understand and agree that I am to wait in the allergy waiting room for at least 20 (twenty) minutes following every injection, at which time I will check out with an allergy nurse as it is important to document any local reactions before the patient leaves the office.

_____ I hereby consent to the administration of inhalant allergy desensitization injections by the physicians and/or staff of Virginia Ear, Nose, Throat & Associates. I am aware that treatment may be three years in duration

_____ I hereby consent to the fulfillment of my financial obligation.

_____ _____
Patient Signature (or Legal Guardian) Date

_____ _____
Patient Number Date of Birth

_____ _____
Witness Date

Virginia Ear, Nose & Throat

PAYMENT AGREEMENT FOR IMMUNOTHERAPY

Patient Name: _____ Patient #: _____

Following is information patients need to understand and agree to prior to initiating immunotherapy:

1. I understand it is my responsibility as the policy holder to have knowledge of my eligibility and insurance benefits.

2. I understand that if my insurance coverage changes I am responsible for notifying Virginia ENT. I also understand that if I fail to provide new insurance information at the time of services that I will be responsible for any charges which are not covered as a result of my not reporting the updated information about my insurance coverage.

3. I understand it is my responsibility to pay my portion of the charges for services if I am subject to a deductible and or co-insurance (co-pay) based on my insurance plan.

4. I understand that once the insurance company has processed my claims (usually by the second or third visit) the amount that I will be responsible for (i.e., the co-pay or the deductible) for my serum vials and injections will be determined. Further, **I understand and agree that thereafter I will be responsible for paying all amounts due at the time of check-in, prior to receiving the scheduled services**.

5. **I understand that if for some reason my balance due exceeds $50.00 I will not be able to receive any additional services until the balance has been paid in full or a payment arrangement has been developed with our Business Office**. Failure to meet either of these stipulations will result in termination of immunotherapy services.

6. I understand that new vials are made prior to the end of the current vial thus **it is required that I give at least 2 weeks' written notice of my intent to discontinue immunotherapy**. Virginia Ear, Nose & Throat has a form that I must sign stating my intention to discontinue immunotherapy. I understand that if I fail to give such notice and new vials are prepared I will be responsible for all charges associated with that service.

7. Virginia Ear, Nose & Throat has provided me with information on PayMyDoctor, a service that allows me to pay my bill online and set up automatic payments for recurrent services.

I acknowledge that I have read the above, all of my questions have been answered, and I understand my responsibilities.

_____ _____

Patient/Representative's signature Date

_____ _____

Witness' Signature Date

Witness' Name_____

Virginia Ear, Nose & Throat

CONSENT FOR USE OF EPINEPHRINE (Epi-Pen)

Patient: _____ **Patient #:** _____

Indications for use of Epinephrine (Epi-Pen)

Life threatening allergic reactions that happen after you have left the Virginia ENT Allergy Office (20 minutes to several hours after testing or after immunotherapy) may consist of any of the following physical signs and symptoms:

Flushing	Cramps
Apprehension	Involuntary voiding
Fainting	Shortness of breath
Rapid heart rate	Persistent cough
Weak pulse	Change in voice (hoarseness)
Vomiting	Itching, rash, swelling of lip, face or other body parts
Diarrhea	

Please read the following two pages on the proper use of the Epi-Pen

Acknowledgement of Understanding

I understand the use of and indications for Epi-Pen intervention. I had the opportunity to ask questions and all of my questions have been answered. I am aware of how to use my Epi-Pen device if an allergic emergency arises. I also understand that if I use my Epi-Pen I should call 911 or have someone take me to the nearest emergency room.

I further understand that I am responsible for bringing my Epi-Pen with me to every shot appointment.

_____ _____

Patient or Representative's Signature Date

_____

Representative's Name & Relationship

_____ _____

Witness' Signature Date