STONE OAK ALLERGY
ASTHMA, ALLERGY & IMMUNOLOGY

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Immunotherapy Treatment Informed Consent

About Immunotherapy

Immunotherapy may be prescribed for treatment of various allergic diseases. The selection of antigen(s) for immunotherapy is based on medical history, healthcare provider examination, and skin testing results. Drug therapy, like antihistamines, may provide an alternative method for symptom relief. In the Austin, Texas area, the common allergens include: ragweed, grass, tree, and dust mites. Venom (hymenoptera) extract immunotherapy is instituted following adverse reactions to wasp, honey bee, yellow jacket, and/or hornet and is confirmed by venom skin test. Perennial immunotherapy is recommended for patients with allergic rhinitis (hay fever) and allergic asthma. Injections are administered weekly for approximately six (6) months, and then every four (4) weeks thereafter. Venom extract injections are administered weekly for ten (10) to sixteen (16) weeks.

Financial Policies for Immunotherapy

Extract vials are custom-created for each patient's specific needs. Initial vials will be created and billed to your insurance carrier prior to starting your injections and, dependent upon the type of immunotherapy chosen, will last between six (6) and nine (9) months. New vials will be created at this time and your insurance carrier will be billed for these. I understand that these remixes will be created prior to needing an allergy injection and I am aware that I will be responsible for any deductibles, copayments, or co-insurances for all remixed vials. I also understand that, should I discontinue treatment or should I decide against treatment after signing this form, that my initial custom-made vials will still be billed to insurance if they have been created, and I will still be responsible for what is not covered by my insurance carrier.

Guidelines

The following are important for the safe and effective administration of allergy immunotherapy and should be followed carefully:

1. Any injection can cause a reaction of **(increased) wheezing, hives, nasal congestion, runny nose, vomiting, diarrhea, or significantly increased shortness of breath.** If this occurs as a result of an allergy injection, it will generally occur within two hours of the injection. If one of these reactions occurs, or if you feel that you have become ill as a result of this injection, you must contact our office immediately. This can be done by calling our office directly or you may go to an emergency room for care. If this occurs, you must see your provider before your next injection.
2. Any injection can cause redness, swelling, or pain at the injection site. If this occurs on the day of the injection, it is a normal reaction. If it lasts until the day after the injection, this should be reported to a nurse prior to your next injection.
3. Patients with high blood pressure, glaucoma, or headache: Please notify our office if your primary care physician gives you a beta blocker for control of your high blood pressure, glaucoma or headache.
4. If you have started any new medications since your last visit, please inform the nurse or healthcare provider before your injection.
5. If you are feeling well, you may receive your injections without waiting to see the doctor. However, we would like to have you see a doctor each time you start new vials.
6. If you are having any symptoms or are sick, please schedule an appointment to see your doctor before receiving an injection.
7. To expedite your visit, please schedule with the receptionist the day you wish to come in for injection or to see the doctor.
8. You must wait in our office for 30 minutes after each injection in case of reaction.
9. Optimum therapeutic results usually require 3-5 years of desensitization therapy. Discontinuation of therapy earlier than this may result in a higher increase of recurrence.
10. Female patients: Not all medications used in treatment of allergic diseases have been cleared for use during pregnancy. If you are planning on becoming pregnant, or are pregnant, please discuss medication use with your doctor.
11. Please inform your primary physician of the allergy medication you are taking, so proper prescribing can occur.

Acknowledgement and Consent

My healthcare provider has discussed with me the need for the tests and procedures described above. I understand the risks and potential benefits of receiving this treatment. I have been warned about the potential reactions that may be experienced during this therapy. I also understand that, although extremely rare, there have been deaths reported in association with receiving allergen immunotherapy. My signature below acknowledges my understanding and gives my authorization and consent to my healthcare provider and staff members to perform these tests, procedures, and render any further medical care.

Patient Name:	Date of Birth:
Signature of Patient or Responsible Party:	Date: