Revere Health
Allergy, Asthma & Immunology

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**

DATE: ____/____/_____

DECLARATION OF INTENT TO BEGIN IMMUNOTHERAPY

Immunotherapy is a common treatment indicated for allergic rhinitis (hay fever) and asthma. My physician has explained the risks and benefits regarding immunotherapy, and has recommended this treatment for me or my child. I understand that immunotherapy is a series of injections (subcutaneous immunotherapy or SCIT, allergy shots) or a series of drops (sublingual immunotherapy or SLIT, allergy drops) that may or may not be covered by my insurance.
It is my responsibility to verify coverage with my insurance.

At this time I would like to begin, or would like my child to begin immunotherapy. I understand that ALL injections will need to be administered in a physician's office.

Provider (circle one)**: Tammy Jacobs, MD / Joshua Burkhardt, DO / Justin Babbel, DO**

Please circle one: SCIT (allergy shots) / SLIT (allergy drops)

Location for SCIT: Orem / Spanish Fork / Lehi (Dr. Kimball) **/ Other**** **Fill out 1) back of this form and 2) physician release form.

Serum:	**SCIT (shots) CPT code: 95165**	**SLIT (drops, NOT COVERED BY INSURANCE)**
Number of vials vary based on number of allergens	$400* per vial	SEE ADDITIONAL NOTE BELOW*** $180 per vial, per month

*Note: Estimated costs for the administration of the injections. Actual costs depend on your insurance plan.

Optional: Rush Immunotherapy (RIT) Protocol CPT code: 95180 - $320*/injection (6, 12, or 18 injections depending 1, 2 or 3 vials).

Venom Immunotherapy (VIT) single venom 95145 = $1000*, multiple venom 95149 = $3600*.
Rapid VIT Protocol CPT code: 95180, $320*/hour; day 1 = 5 hours, day 2 = 3 hours, day 3 = 2 hours (approximately) + cost of medications.

We will bill this cost to your insurance company, unless you're choosing SLIT. The serum expires after one year. If you come in as directed, you'll run out of serum in approximately 4 months for injections, and 1 month for SLIT.

SCIT (Allergy Shots – CPT code: 95115 or 95117):

One injection: $30*
Two or three injections: $40*

*Note: Estimated costs for the administration of the injections. Actual costs depend on your insurance plan.

MEDICAID

☐ **Please check if you have a Medicaid plan**. This may be a covered benefit of your plan, but currently coverage is limited a certain allotted number of units per 12 month period. After that, we will no longer bill insurance, and you will be responsible for the full cost of the refill serums up front. ***If you have a Medicaid plan, you are required to sign an Advance Beneficiary Notice of Noncoverage (ABN) form attesting that you understand your financial responsibility.*** ***Please initial*** ☐

***SUBLINGUAL IMMUNOTHERAPY (SLIT) ALLERGY DROPS

Allergy drops: You will be responsible for the cost of the allergy serum which is refilled more often than with allergy injections. SLIT is not covered by any insurance in Utah or the United States. SLIT cannot be billed to your insurance company. ***Please initial ☐

Please call your insurance company to find out how they will cover allergy injections and allergy serum. SLIT is not a covered benefit; therefore, you will be responsible for the cost.

AGREEMENT OF FINANCIAL RESPONSIBILITY- MEDICAID

Patient Name Last, First, Mi	Date of Birth (Mo/Day/Yr)	Medicaid ID #

Section 1 (Provider completes this section)

Description of non-covered service(s), for which the patient agrees to accept financial responsibility:

_____

_____

Expected cost of non-covered service(s) $_____

Expected date of service_____/_____/_____

The provider of services,_____, certifies that this office has an established policy for billing all patients, for services not covered by a third party. In accordance with state Medicaid provider billing guidelines, the patient has been advised prior to services being rendered the specific non-covered services(s) to be provided and the expected cost.

Completed by (print)_____for the above provider.

Signature:_____Date_____

Section 2 (Patient or responsible party completes this section)

I am the patient or responsible party. I understand my health plan may not pay for the services described in Section 1. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed and agree to pay the bill as described in Section 1.

Signature of Patient or Responsible Party:_____Date_____

Responsible Party, if other than patient (print):_____

Relationship to Patient:_____

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DECLARATION OF INTENT TO BEGIN IMMUNOTHERAPY

***** You MUST take an antihistamine at least one hour prior to your allergy injection.**
***** You MUST carry an epinephrine autoinjector on allergy injection days. Pharmacy:**
***** FOR YOUR SAFETY: In the unlikely chance that you have a reaction, you may be treated in a neighboring Urgent Care facility or physician with subsequent charges from that physician or department. If the reaction is severe or life-threatening, you may be transported to the nearest Emergency Department with subsequent charges from that department.**

Advance Beneficiary Notice of Noncoverage (ABN)

This procedure is considered standard of care or common practice for your medical problem. However, your medical insurance may not pay for this procedure. It is the patient responsibility to check coverage prior to the procedure. You will be responsible for payment if your insurance does not cover this procedure.
Your medical insurance does not pay for everything, even some care that you or your health care provider have a good reason to think you need.

Medication or Procedure*	Reason Your Insurance May Not Pay	Estimated Cost
See checked for service/procedure and CPT code	Policy Limits; Unit Limit; Non-Covered Item	See estimated pricing above

WHAT YOU NEED TO KNOW

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading this.

***I consent to the procedure as listed above, and I accept financial responsibility.**
Signing below means that you have received and understand this notice.

Signature:	**Date:**

Patient Signature (patient or guardian)

Relation to patient: _____ **(if not self)**

Phone: (_____) _____-_____

********Please fill below if you obtain your injections at another physician office.***

If you obtain your injections at another physician office (otherwise leave blank) – Delivery options:

☐ Office Pick-up. *If you select office pick-up, but are unable to do so, and need us to mail it out instead, we will require a written statement mailed or faxed to us, with S&H payment prior to shipment (payment can be made over the phone).* ***Please initial _____.***

☐ Mail Out to ($25/bottle S&H due prior to shipment): _____
Accepting Physician Address

There are risks to mailing the serum, as the serum may degrade in temperature extremes, thus rendering the serum less effective. Please note that we are also not responsible for lost or damaged serums in the mail. ***Please initial _____.***