Revere Health
Allergy, Asthma & Immunology

(Office Only) MRN: ____________________

PATIENT NAME: ____________________

DOB: ___/___/_____ AGE: _____ SEX: M / F

Doctor: (circle one) **JACOBS** or **BURKHARDT** or **BABBEL**

DATE: ___/___/______

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOTS) SERUM REFILL FORM

1) **Please fill out completely and return or fax back for refills.**
2) **Please attach or fax the injection record form(s) with this request.**
   ***Please allow 2 weeks for serum refills and delivery.

Bottle: ________ Dilution: ________________ Dose: _________

Bottle: ________ Dilution: ________________ Dose: _________

Bottle: ________ Dilution: ________________ Dose: _________

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*** ☐

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 ________.**

SUBCUTANEOUS IMMUNOTHERAPY (ALLERGY SHOTS) SAFETY GUIDELINES AND CONSENT

I understand that among the risks of subcutaneous immunotherapy are immediate reactions, delayed reactions, severe allergic reactions, and other reactions. I also understand that, as with every treatment, there is a possibility of unexpected complications.

The following specific risks were discussed with me:
IMMEDIATE REACTIONS: The risks of immediate allergic reactions include: large local reactions involving itching and swelling (most commonly); but also includes generalized itching, rash, hives, swelling of the lips, tongue, or throat, chest pain, chest tightness, shortness of breath, wheezing, abdominal pain, nausea, vomiting, diarrhea, palpitations, dizziness, confusion, anaphylaxis, shock, and death.

DELAYED REACTIONS: The risks of delayed allergic reactions include: large local reactions involving itching and swelling (most commonly); but also includes generalized rash and itching. Unusual reactions may include liver or kidney involvement, fevers, chills, joint pains, and ulcerations.

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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SAFETY GUIDELINES

For all patients starting or on allergen immunotherapy injections, please note the following guidelines to reduce the risk of serious and life-threatening allergic reactions.

1. **BUILD-UP SCHEDULE:** During build-up period, receive injections twice a week when possible, with at least 24 hours and preferably two days between injections. No more than two injections a week.
2. **NO EXERCISE BEFORE/AFTER INJECTION:** Do not exercise for one hour before and two hours after your injection.
3. **ANTIHISTAMINES:** Take an antihistamine (i.e. Zyrtec/cetirizine, Allegra/fexofenadine, Claritin/loratadine) at least 1 hour prior to receiving your allergy injection. If antihistamines make you drowsy, you can take your antihistamine the night before your injection.
4. **OBSERVATION PERIOD:** Wait at least 30 minutes after your injection before leaving the doctor's office (mandatory). If you choose to leave earlier against medical advice, then you must sign a form attesting that you understand the risks.
5. **EPINEPHRINE AUTOINJECTOR:** Carry an up-to-date epinephrine autoinjector on days you are receiving injections.
6. **INJECTION ONLY WHEN HEALTHY:** Do not get an injection if you are sick, have a fever, cold, chest congestion, wheezing, or any symptoms of asthma or severe allergies.
7. **MINORS:** If the shot patient is under the age of 14, a parent or guardian must be present at the time of the injection.
8. **REPORT SYMPTOMS AND PREGNANCY:** Tell the nurse immediately:
    a. If after an injection you experience any generalized symptoms (such as hives, hay fever, coughing, asthma, dizziness, flushed face).
    b. If you are pregnant. Although allergy injections may be continued at maintenance dose while a person is pregnant, the dose cannot be increased during pregnancy. Please make an appointment with the doctor if you become pregnant while receiving allergy injections.
9. **REPORT DELAYED REACTIONS:** If you experience a delayed shot reaction after you leave the doctor's office, report the reaction in detail, along with any treatment you received, at your next injection.
10. **INJECTION SCHEDULE:** Your injection schedule will be modified or the frequency of your injections can be increased for reasons including but not limited to:
    a. Starting new vials
    b. Missed injections due to vacation, illness, or other reasons.
    c. Large local or systemic reactions
    d. A change in extract formula
11. **DURATION OF THERAPY:** To receive maximum benefits allergy shots should be taken all year round for 3-5 years. The effectiveness of these injections is diminished and your cost increases when the injection schedule is interrupted. Extracts expire one year after they are made. When new extracts or dilutions are required, the usual and customary fees will apply.
12. **REPORT CHANGES TO HEALTH:** It is important that you give complete and accurate medical information to the doctor and staff giving the injections— failure to do so can have serious, even life-threatening consequences.
13. **TREATMENT CONSENT:** In the unlikely event that you have a reaction, you may be treated in the clinic. Because allergic reactions can occur and worsen quickly, prompt medical treatment is critical. Treatment may include antihistamines, bronchodilators, corticosteroids and epinephrine, and can be in the form of oral, inhaled or injection medications. ***You may also 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.

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14. **TERMINATION OF IMMUNOTHERAPY: Your safety is our top priority. If safety guidelines are disregarded, or if prompt treatment of potentially life-threatening reactions are refused, the doctor has the right to terminate immunotherapy, because in those cases the risks may outweigh the benefits. Allergen immunotherapy is one of the most beneficial treatments for allergic patients, but it has an unlikely but potentially serious risk. That risk is only minimized and mitigated when recommendations are followed and reactions are treated.**

15. **ANNUAL VISITS: You need to be seen by the doctor at least once a year in order to continue your immunotherapy prescription.**

Patient Attestation: I have had an opportunity to read, discuss and understand regarding the risks and benefits of this procedure and of the alternatives with my physician. I have had an opportunity to review and ask questions regarding the above guidelines to minimize risk of serious and life-threatening reactions. I have had an opportunity to ask about medical treatment in the case of an allergic reaction, and I consent to prompt treatment for allergic reactions. All my questions have been answered to my satisfaction, and I consent to this treatment.

*****Serums can only be refilled if there has been a doctor's visit within one year.**
If it has been more than 1 year since the last doctor's visit, please make an appointment, or serum refill and treatment may be delayed.

If you would like to refill your serums, and agree to the safety guidelines and treatment above, please sign and date below. If you have any questions, please call us at (801) 226-3600.

Advance Beneficiary Notice of Noncoverage (ABN)

Your medical insurance may not pay for the ALLERGY SERUM below. You will be responsible for payment.
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. We expect your medical insurance may not pay for the medication or procedure ALLERGY SERUM below.

Medication or Procedure*	Reason Your Insurance May Not Pay	Estimated Cost
ALLERGY SERUM (SCIT)	Policy Limits; Unit Limit; Non-Covered Item	$400 per vial
ALLERGY SERUM (SLIT)	Policy Limits; Unit Limit; Non-Covered Item	$180 per vial/per month

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.

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: (______) _______-___________