AGAPE ALLERGY
& Immunology Associates

Immunotherapy Checklist Form

_____ Immunotherapy was discussed with the Physician

_____ I was given and have reviewed the immunotherapy information packet

_____ I have returned the following four forms:

Patient Financial Responsibility Form

Immunotherapy Financial Consent Form

Immunotherapy (Allergy Shots) Consent

Shot Patient Emergency Contact Information/Liability waiver

_____ I returned these four forms by either:

Completing them in the office

Mailing to: Agape Allergy & Immunology Associates

46 Daggett Drive, Suite 1A

West Springfield, MA 01089

Once the Immunotherapy Consents are received

1. The physician places the order for your immunotherapy

2. The order is approved, and serum is made

3. The office will contact you to set up the first allergy shot appointment

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Patient Financial Responsibility Form – Allergy Shots

Patient Name: _____Insurance Company: _____

Your physician is recommending allergen immunotherapy for you or your child.

Please call your insurance company at the Member Services phone number to confirm that this is a covered benefit. Provide the following highlighted procedure codes to the insurance company.

Allergy Shot Procedure Codes

95115 Administration of Single Injection

95117 Administration of Multiple Injections

95165 Multiple Dose Vial – billed per unit **

**Units billed may vary from 6 units – 200

Are the injections covered? No ☐ YES If yes:

Do I have a deductible? NO ☐ YES ☐ $_____ Deductible Met: $_____

Do I have a co-insurance? NO ☐ YES ☐ _____%

Do I have a copay? NO ☐ YES ☐ $_____

Is there a maximum/limit on number of 95165 units? NO ☐ YES ☐

If Yes how many _____ per: _____year/days

Is there a maximum/limit on number of 95115/95117 injections? NO ☐ YES

☐ If Yes how many _____ per: _____year/days

The name of the person you spoke with:
_____ Date: ____/____/____ Time: _____ am/ pm Reference Number for Call: _____

PLEASE NOTE: The serum is created specifically for you or your child. If you decide to not initiate the allergen immunotherapy after the serum has been made or decide to discontinue the program without consulting your provider, your insurance company will be billed. You may be responsible for a portion of the cost. This form must be completed, signed, and returned to our office prior to starting immunotherapy.

Signature: _____ Date: _____

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Immunotherapy Financial Consent Form

Patient Name: _____ Contact Number: ( ) -

DOB: _____

Insurance plans are highly variable regarding coverage of immunotherapy treatment. There are two costs to consider. The first cost is for the "antigen" or "extract" (95165). The antigen (extract) is prepared at Agape Allergy & Immunology Associates, LLC from a prescription your physician has written. The second cost is for the administration of the injections (95115 or 95117). Your therapy is built up in 4 levels. All 4 levels are created at the same time (a kit) because the strongest is made first and diluted down to your starting dose. Depending on your insurance you will either be billed up front for all 4 levels or billed for each level individually as you advance (Bill by level).

Agape Allergy & Immunology, LLC recommends that you contact your insurance carrier(s) to verify your specific coverage. It is important to understand your insurance coverage and know your responsibility for the cost. Some Insurance plans cover immunotherapy in full, while other plans have associated deductibles, co-insurances and co-pays.

➢ I acknowledge, with my signature, that I am authorizing Agape Allergy & Immunology Associates, LLC to bill my insurance company for the allergen extracts made for me/my child. I understand that, if I decide not to initiate allergen immunotherapy after the extracts have been made, I am still responsible for the cost of the extract. I acknowledge that any costs incurred for this method of treatment that is not covered by my insurance carrier, such as deductibles, co-insurances, or co-pays will be my responsibility. I also acknowledge that my allergen extracts will not be prepared until this signed consent is returned to Agape Allergy & Immunology Associates, LLC.

I authorize the preparation and billing of the allergen extract.

Responsible Party Name (print) _____ Date _____

Responsible Party Signature _____ Date _____

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Immunotherapy Information & Consent

Immunotherapy (allergy shots) is an attempt to build a resistance or tolerance to the things to which you are allergic. Seventy to eighty percent of those placed on allergy shots are helped to a significant degree. You may need to take antihistamines, decongestants, nasal sprays, or asthma therapy with the injections in order to feel well. ALLERGY SHOTS ARE A SUPPLEMENT TO ENVIRONMENTAL CONTROL AND/OR MEDICAL MANAGEMENT WHERE THOSE MODES OF THERAPY HAVE FAILED TO BRING ABOUT THE DESIRED BENEFIT. It must be understood that allergy shots are a time and financial commitment. They are used to reduce future, not current, symptoms.

Allergy shots are given once or twice a week starting with a very dilute (weak) dose. Each week the dose is increased until a maximum level is reached. This is called the maintenance dose. Provided you adhere to the schedule and things go as planned, this build-up phase will take approximately six months. Shots are then given every two, three, and eventually four-week intervals. Allergy shots are not given at intervals greater than four weeks with the exception of insect sting allergy, which can be given up to every six weeks. If you go more than two to three weeks from your scheduled shot date, dose and schedule changes will have to be made.

Most patients may not see any significant improvement in their symptoms for six months. In some cases, improvement may take longer. The average treatment course is four to five years with the patient receiving injections once per month.

Reactions: As you are receiving extracts to which you are allergic, it is possible that a reaction may occur.

Local: Redness, swelling, and itchiness at the site of the injection similar to a mosquito bite or insect sting. These reactions usually occur within 20 minutes after the injection, although they can occur hours later. They will usually clear in 24 to 48 hours.

Systemic: The symptoms of a systemic reaction may include itchy skin, itchy eyes, itchy ears and throat, coughing, congestion, sneezing, wheezing, throat tightness and hives. This reaction occurs usually within 30 minutes after the injection. Systemic reactions can be dangerous. Early recognition is important so that treatment can be started. ·

Our patients and parents are required to wait 30 minutes in the waiting room.

·On day of shots, you should carry an antihistamine and your epinephrine autoinjector with you. We can provide you a prescription for one.

After leaving the office, should symptoms of tightness of the throat, difficulty in breathing, or any other symptoms of a systemic reaction occur, emergency medical treatment should be sought at our office or the nearest Emergency Room. After you are stabilized, our office should be notified as soon as possible.

Local reactions that occur on the arm are used as a guide for further treatment. Please report them to the nurse prior to administration of the next shot. Should they become uncomfortable at home or in our office, ice packs and an antihistamine can be given. If you have asthma, you should carry your Bronchodilator inhaler with you.

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Allergy shots can be potentially dangerous. Persons have died from shots (estimated 1 death every 2.5 million shots). We cannot give allergy shots if you are feeling uncomfortable from allergies, asthma, a cold or fever. Please let the nurse know if you are not feeling well BEFORE your shot is given. Proper medical treatment should be instituted and shots rescheduled.

For best results, we would like you to be committed to getting your shots regularly. If you need to be away for an extended period of time, please let us know and arrangements may be made for you to receive your immunotherapy elsewhere. Allergy shots cannot be given at your home. They can be given at a college infirmary, business medical office or summer camp if a doctor is on site and available to treat potential systemic reactions.

Once you are receiving your allergy shots monthly, you are expected to see your allergist on a regular basis, at least once per year (or more frequently if you have asthma). These visits are important so that the doctor can determine the effectiveness of the therapy and modify it if necessary.

Please notify the nurse or physician if you are taking any new medications (specifically Beta Blockers which are used in the treatment of high blood pressure, heart disease and migraine headaches). Patients on Beta Blockers should not receive immunotherapy unless the increased risks have been discussed and consented to with the treating Agape physician.

Should you become pregnant, allergy shots can be continued with some adjustments of dose. We generally do not start pregnant patients on allergy shots.

Depending on your insurance coverage, you may need to pay a co-pay and/or a deductible towards your extracts and/or injection administration.

Please call us with any questions you may have at 413-707-7720

I, , have been made aware of the risks and obligations involved in receiving allergy injections therapy. Parents must remain in waiting room with patients under 16 years of age.

Patients Name	Patients or Guardians Signature	Date
_____	_____	_____

Witness	Date
_____	_____

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Immunotherapy Injection Liability Waiver

Receiving an immunotherapy injection is a procedure. With any procedure, there are potential risks. I understand that the allergens used in this treatment poses significant risks, some of which are relatively common and others that are rare and unforeseeable. Some patients experience few or no side effects from treatment. Others suffer significant complications. I understand that I may suffer any of the complications/side effects immediately following the injection or within 8-10 hours after the injection. These reactions may consist of any or all of the following symptoms:

- Mild reactions: Itchy eyes and nose, nasal congestion, runny nose, mild headache, redness, itching, pain, or swelling in the area around the injection site, tiredness, and flu-like symptoms
- Serious reactions: Tightness in the throat or chest, shortness of breath, coughing, wheezing, light-headedness, faintness, nausea and vomiting, hives, generalized itching, and shock, the last under extreme conditions. Reactions even though unusual, can be serious and rarely fatal.

A consent form was signed agreeing that if you have an allergic reaction to the injections that the physician-in-charge has permission to treat the reaction. Additional treatment may be necessary including other medications, fluids, and protection of your ability to breathe by inserting a tube into your throat. The physician may decide to send you to the hospital for follow up care and monitoring, especially if Epinephrine was used. Safety transportation does not allow additional minors to be transported in the ambulance, which is why patients are advised to not bring additional minors to procedures. Our office cannot be responsible for childcare, but we do realize that sometimes exceptions need to be made for those who do not have childcare.

Please list below emergency contacts that we can call that will be available for your appointment that can come and pick up your minor(s) in the event you have an emergency. If the emergency contact(s) do not respond or are unable to come, then we would need to make alternate arrangements which could result in calling the Department of Children and Families.

By signing below, you agree to these terms, and also release Agape Allergy and Immunology Associates LLC from all liability and possible costs that could result.

Emergency Contact #1	Emergency Contact #2	Emergency Contact #3
Name:_____	Name:_____	Name:_____
Contact #: _____	Contact #: _____	Contact #: _____
Address:_____	Address:_____	Address:_____
Relationship:_____	Relationship:_____	Relationship:_____

Signature of Patient: _____ Date: _____
(Parent/Guardian of Minor(s))

MRN: _____

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Immunotherapy – No Additional Minors

Receiving an immunotherapy injection is a procedure. With any procedure, there are potential risks. I understand that the allergens used in this treatment poses significant risks, some of which are relatively common and others that are rare and unforeseeable. Some patients experience few or no side effects from treatment. Others suffer significant complications. I understand that I may suffer any of the complications/side effects immediately following the injection or within 8-10 hours after the injection. These reactions may consist of any or all of the following symptoms:

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- Serious reactions: Tightness in the throat or chest, shortness of breath, coughing, wheezing, light-headedness, faintness, nausea and vomiting, hives, generalized itching, and shock, the last under extreme conditions. Reactions even though unusual, can be serious and rarely fatal.

A consent form was signed agreeing that if you have an allergic reaction to the injections that the physician-in-charge has permission to treat the reaction. Additional treatment may be necessary including other medications, fluids, and protection of your ability to breathe by inserting a tube into your throat. The physician may decide to send you to the hospital for follow up care and monitoring, especially if Epinephrine was used. Safety transportation does not allow additional minors to be transported in the ambulance, which is why patients are advised to not bring additional minors to procedures. Our office cannot be responsible for childcare.

By signing below, you are agreeing to not bring additional minors to immunotherapy injection appointments, and to notify the office if there is a need to reschedule your appointment.

Signature of Patient: _____ Date: _____
(Parent/Guardian of Minor(s))

MRN: _____