Immunotherapy Financial Consent Form
For Refills of Antigen

This is to notify you that your antigen is expiring or vial is empty. To refill your antigen, the set(s) will be sent to our Antigen Lab at our Denver location. This refill will take approximately 14-21 days. When the refill has been completed, it will be returned to your location. The staff will then notify you that you may resume your injections.

The charges for the refill will be billed to your insurance. Please be aware that your insurance may have changed from last year and you may want to contact them for clarification of your current coverage. You are responsible for any remaining balance. Please make sure that we have your current insurance information.

- *I acknowledge, with my signature, that I am authorizing Colorado Allergy and Asthma to bill my insurance company for the allergy extracts made for me.*
- *I understand that, if I decide not to continue allergen immunotherapy after the extracts have been made, I am still responsible for 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 acknowledge that my allergy extracts will not be prepared until this signed consent is returned to my Colorado Allergy and Asthma physician.*

□ **I authorize the refill and billing of the antigen.**

□ **I have submitted my most current insurance information to CAAC.**

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient or Responsible Party Signature Date

Special Instructions:

___ Refill Now

___ Refill When Sets Expire

Other: _____