COLORADO ALLERGY & ASTHMA CENTERS, P.C.
Breathe Better - Live Better!

Leaders in Allergy & Asthma Care Since 1972

Immunotherapy Financial Consent
For Refills of Antigen

Patient Name: _____ CAAC #: _____ DOB: _____

This is to notify you that your antigen is expiring, your vial is empty, or refill due to antigen revision. 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 the clinic where you receive allergy shots. The staff will then notify you that you may resume your injections.

Any unpaid balance over 90 days will delay the refill. The charges for the refill will be billed to your insurance or to your self-pay account. Please make sure that we have your **current insurance information**. 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(s).

- *I acknowledge, with my signature, that I am authorizing Colorado Allergy and Asthma (CAAC) 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.*

Please review and **initial** each of the following:

_____**I understand any unpaid balance shall be addressed with billing department before refill is approved**

_____**I authorize the preparation and billing of the antigen for the following reason (check one):**

☐ Antigen refill ☐ Bridge vial refill

☐ Revision to recipe

_____**I have submitted my most current insurance information to CAAC. I understand that if my insurance is not current information, my refill may be delayed.**

_____**I authorize the storage of my payment information on file and charge it for the final amount, deemed to be my financial responsibility, for the healthcare services provided today and for any ongoing immunotherapy (allergy shots and/or serum) charges.**

_____

Patient or Responsible Party (PRINT)

_____ _____

Patient or Responsible Party Signature Date

For Office Use:

Special Instructions:

___ Refill Now ___ Refill When Sets Expire

Other: _____ ___ Card on file