Immunotherapy Financial Consent

Patient Name: _____
Account Number: _____

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 is prepared in our laboratory from a recipe your physician has written. Your antigen is specific only to you and contains what you are allergic to. The cost for antigen varies based upon how often you are prescribed to receive shots and how many vials of antigen are made because of the amount of allergens for which you have an allergy. The second cost is for the administration of the injections (95115, for one shot) or (95117, for multiple shots).

We assist you with Insurance Verification by providing you with an ***estimate*** of benefits and the "out of pocket" cost. We recommend that you contact your insurance carrier to find out your specific coverage. It is important to understand your insurance coverage and know your responsibility of 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 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 will not, however, have the cost of the administration of the antigen.*
- *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 authorize the preparation and billing of the antigen**

_____**I have submitted my most current insurance information to CAAC**

_____**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:

☐ Card on file