CONSENT FOR ADMINISTRATION
OF ALLERGY IMMUNOTHERAPY (AIT) AND/OR VENOM IMMUNOTHERAPY (VIT) AUTHORIZATION FOR TREATMENT

I have read the information in this informational sheet and consent form and understand it. I have had the opportunity to ask questions regarding the potential risks of AIT, office policies and any billing procedures, and these questions have been answered to my satisfaction. I understand AAA will take precautions consistent with best medical practices to protect me from adverse reactions to AIT if and when they may occur in the course of my treatment. I do hereby give consent for the patient designated below to be given AIT (allergy injections), as prescribed by Dr. Courtney J. Blair, Dr. Sharon Seth, or Bridget Schaefer, P.A, or another licensed provider working for Allergy and Asthma Associates, P.C. I further hereby give authorization and consent for treatment, by Allergy and Asthma Associates and their medical providers, staff, for any reactions that may occur as a result of an AIT injection.

I am consenting to: [ ] **AIT** and/or [ ] **VIT**, as outlined on all pages of this document.
[ ] **McLean** Office, [ ] **Sterling** Office, [ ] At **another medical facility** (Complete a Request to Transfer Form)

I am consenting to: [ ] **RUSH** Immunotherapy or [ ] **Conventional** Immunotherapy

I have reviewed the shot hours/policies and understand any possible scheduling limitations _____ **(initial)**
I have reviewed my insurance policy and understand my out of pocket responsibilities for AIT/VIT _____ **(initial)**

Primary Insurance:_____ Member ID:_____ Group #:_____

Secondary Insurance:_____ MemberID:_____ Group #:_____

When the request is complete, I'd like to be notified: (Choose one)

☐ Portal message

☐ Text message:_____ ☐ Phone call:_____

_____ _____
Printed Name of AIT/VIT Patient Date of Birth

_____ _____
Patient Signature or Legal Guardian Date Signed

FOR OFFICE USE ONLY:
I certify that I, or my staff, have counseled this patient and/or authorized legal guardian concerning the information in this Consent for Immunotherapy and that it appears to me that the signee understands the nature, risks, and benefits of the proposed treatment plan.

_____ _____
Courtney J. Blair M.D., Sharon Seth M.D., or Bridget Schaefer, P.A **Date Signed**