



Allergy and Asthma Associates, P.C.
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AAA SLIT RENEWAL CONSENT

By signing below, I confirm that I have read (or had read to me) all of the information previously provided in the initial AAA SLIT consent. I understand the nature, benefits, and risks of Sublingual Allergy Immunotherapy, and all of my questions have been answered to my satisfaction. I consent to continue this treatment as outlined.

I must return this completed form via the patient portal or drop off a physical copy and am responsible for an active card on file for payment (otherwise vials will NOT be made).

I consent to receive Sublingual Allergy Immunotherapy (SLIT) for the treatment of my allergies. I have read (or had read to me) the information on SLIT, and my questions have been answered to my satisfaction.

I understand and acknowledge the information above.

Patient's FULL NAME: _____ **Date of Birth** ____/____/____

Patient (or Guardian) Signature _____ **Date Signed** ____/____/____

Desired Pick Up Date *a minimum of 2 weeks from the date this form is signed ____/____/____

* Card on file will be charged when SLIT vials are made (based on selected pick up date)

Desired Pick Up Location _____ **Sterling** _____ **McLean**