GRANGER MEDICAL CLINIC

Education for Immunotherapy

Name: _____ MRN: _____

The following statements are intended to help educate you regarding allergy immunotherapy. Please review the statements and initial to indicate your agreement.

Initials	
	I have read the handout titled "Patient Fact Sheet: Immunotherapy."
	I understand that allergy immunotherapy is a 5-year commitment.
	I understand the risks and possible complications of immunotherapy. I have had an opportunity to discuss my concerns and ask questions, and my questions have been answered to my satisfaction.
	I understand that I have an integral role in achieving the objectives of immunotherapy, and that no success is possible without my active participation.
	I acknowledge that I have received no express, or implied promises, guarantees, or warranties regarding the results that will, or may, be achieved by the proposed healthcare.
	I understand that there is a charge for each shot given, and a charge every 9 to 12 months for extracts. I understand that it is my responsibility to verify the coverage provided by my insurance carrier, and that I will be responsible to pay any balance that my insurance carrier refuses to cover.
	I understand that the extract for immunotherapy has an expiration date. I also understand that If I delay starting shots or treatment and the extract expires, I will be responsible for an additional charge to replace the extract.
	I understand that if I have Medicare or Medicaid I must call the office prior to coming in for a shot to ensure that a physician will be in the office when my shots are given.
	I understand that allergy shots are to be given only in a clinical setting so that emergency care can be given in the event of a reaction.
	I understand that anaphylaxis, a life-threatening reaction, is possible (although rare).
	I understand that I will be required to wait 30 minutes in the clinic following **every** injection.
	I understand how to use an EpiPen. I also understand that I am to carry an EpiPen with me on the days that I receive allergy shots.
	I understand that I will not receive my allergy shot if I have had asthma symptoms in the past 24 hours, have a fever, or am not feeling well.
	I understand that I must notify the staff if I am pregnant, diagnosed with a new medical condition, or change the medications that I am taking.
	I understand that I must follow-up with the physician when new extracts are needed. I also understand that I will be required to have a yearly check-up with the physician.

I have read, or had the opportunity to read, and understand the information above. My questions have been answered satisfactorily.

Patient or Representative Signature: _____ Date: _____ Time: _____

Relationship of Representative to Patient (if applicable): _____

Witness Signature: _____ Date: _____ Time: _____

Interpreter's Name (if applicable): _____