Medicare Patient Only:

I acknowledge that my allergy treatment plan will include immunotherapy (allergy shot) program. The risk and benefits of this treatment plan have been discussed with me. I have been provided with both written and verbal information regarding how immunotherapy works, possible adverse reactions and limitations of such treatment.

I understand that while immunotherapy is quite safe, there is a chance of a generalized reaction (anaphylaxis) which, if untreated, can be life threatening. I agree to remain in the office **20 minutes** following my injection to be observed for any adverse reactions.

I agree to start immunotherapy treatment and I accept financial responsibility for the allergen vaccine, which will be prepared and upon my signed consent. I understand there will be a RECURRING ANNUAL charge, if I choose to continue allergy injections as a part of my treatment program.

___________________________________ ____________________

Signature of Patient or Parent/Guardian Date