ALPINE ALLERGY CLINIC
Adult and Pediatric Allergy Testing and Treatment

ALPINE
EAR, NOSE & THROAT, P.C.

# *Immunotherapy Consent*

After completing your allergy testing and consultations with your physician, you have chosen to use Immunotherapy to treat your symptoms. Immunotherapy has the advantage over drugs in that it treats the underlying causes of your symptoms. Drugs treat only the symptoms and they do not treat the source of the allergy. The likelihood of success of this treatment is excellent, however as with any medical procedure, it depends on your compliance with the recommended schedule. Please read the below information and ask any questions before signing. This form and further information can be found at: www.alpineallergyclinic.com

1. I understand that allergy immunotherapy, subcutaneous immunotherapy (SCIT) and sublingual immunotherapy (SLIT) is the process by which an "allergic" patient is made less sensitive to a specific allergen. This reduction in sensitivity is accomplished by repeated injections or drops placed under the tongue following a set protocol.
2. I understand that allergy immunotherapy does not take the place of avoidance of allergens to which I am known to be sensitized (allergic) and that the overall effectiveness of this injection treatment program also depends on my complying with recommendations with respect to environmental controls and use of medications.
3. I understand that reduction of allergic sensitivity is the goal of allergen immunotherapy. Improvement will not be seen immediately, and may not be apparent for up to one year. The results are often a significant reduction, but not complete elimination of symptoms. A few patients may not be helped by immunotherapy at all. I recognize that there is no guarantee that this therapy will, in fact, result in a cure or resolution of my symptoms.
4. Associated expenses with immunotherapy: There are continuing expenses with immunotherapy, extracts formulation and injections will be charged at the time of service. Options for payment include: payment at the time of service and bi-weekly payments, not to exceed any 30 day period. The details are outlined below.
    a. I understand that once the allergy extracts are prepared, I am responsible for the expense. Therefore, I recognize that I should contact my insurance company to inquire about medical coverage of the allergy immunotherapy extracts.
    b. For subcutaneous Immunotherapy (SCIT) there will be an associated cost per injection for which I am responsible for the expense. Therefore, I recognize that I should contact my insurance company to inquire about medical coverage of the allergy injections before I sign this consent.
5. I understand that I will be receiving subcutaneous Immunotherapy (SCIT) or sublingual Immunotherapy (SLIT) of substances to which I am allergic and that reactions to allergy injections or sublingual drops may occur.
    a. For subcutaneous Immunotherapy (SCIT) it is not unusual for swelling and itching to occur at the site of an injection. Occasionally other reactions may occur. These reactions include: generalized itching, hives, fainting, shortness of breath, or tightness in the throat or chest.
    b. For sublingual Immunotherapy (SLIT) a slight taste will be noticed and possibly a tingling sensation may be felt, reported reactions are rare. Other potential reactions include: generalized itching, hives, fainting, shortness of breath, or tightness in the throat or chest.
    c. I recognize the possibility that life-threatening reactions could occur such as anaphylaxis, shock, and death.
    d. I understand that Beta Blockers may reduce or stop the effectiveness of emergency treatment if you experience anaphylaxis. If you are currently on or begin using any type of beta blockers you must inform us as soon as possible. If you choose to continue immunotherapy you acknowledge the potential risks associated with beta blocker usage.
    e. EPI –PEN – Prescriptions for epi-pens are offered for your protection at the beginning of your treatment and any time during your therapy. It is strongly suggested that you fill your prescription before your treatment begins. Proper use and training will be provided during your first visit and anytime requested.

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I have read and fully understand this consent form, and agree to be treated with Subcutaneous Immunotherapy (SCIT) or Sublingual Immunotherapy (SLIT) and understand all the risks and benefits associated with therapy and agree to pay all related expenses. I may discontinue treatment at any time. I understand that I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the items or words contained in this consent form.

_____ (Initial) - I understand the warnings and potential effects of Beta Blockers use during Immunotherapy.

### Please check which therapy chosen:

**Subcutaneous Immunotherapy (SCIT) Allergy Shots** ☐

**Sublingual Immunotherapy (SLIT) Allergy Drops** ☐

### Treatment location:

**Fort Collins** ☐

**Loveland** ☐

_____
**Printed Name:**

_____
**Signature:** **Self/Patient/Guardian**

_____
**DOB: MM/DD/YY**

_____
**Date: MM/DD/YY**