**ALLERGY CARE OF MANHATTAN**

 **AND**

**VR ALLERGY AND ASTHMA CARE, PLLC**

DR. NATHAN SAINT-AMAND – DR. IRA FINEGOLD – DR. VAHID RAHIMIAN

**IMMUNOTHERAPY FINANCIAL CONSENT FOR ANTIGEN MIX REFILLS**

This is to notify you that your antigen is expiring or vial is empty. The refill will take approximately 1-2 weeks. When the refill has been completed the staff will notify you that you may resume your injections or you can call the office to check the status.

The charges for the refill will be billed to your insurance company. Please be aware that your insurance may have changed from last year and you may want to contact them for clarification of your current coverage. You are responsible for any remaining balance. Please make sure that we have your current insurance on file.

* *I acknowledge, with my signature, that I am authorizing Dr. Nathan Saint-Amand, Dr. Ira Finegold, or Dr. Vahid Rahimian to bill my insurance company for the allergy extracts made for me.*
* *I understand that if I decide not to continue allergen immunotherapy after the extracts have been made, they will still be billed to the insurance company and I will still be responsible for any deductibles, co-insurance, and/or copays as per my plan.*
* *I acknowledge that any costs incurred for this method of treatment that is not covered by my insurance company, such as deductibles. co-insurances, and/or co-pays will be my responsibility as per my plan.*
* *I acknowledge that my allergy extracts will not be prepared until this signed consent is returned to the office.*

□ **I authorize the refill and billing of the antigen mix.**

**□ I have submitted my current insurance information to your office. I also acknowledge that I am responsible for fully understanding my insurance.**

**□ I authorize the storage of my payment information on file and charge it for the final amount, determined to be my financial responsibility, for the healthcare services provided today and for any ongoing immunotherapy (allergy shots and/or serum) charges.**

**□ I do not authorize to charge my card on file until someone has explained to me the charges I am responsible for.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Responsible Party (PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Responsible Party Signature Date