ALBANY ENT & ALLERGY SERVICES, P.C.
400 Patroon Creek Boulevard, Suite 205
Albany, New York 12206
Phone (518) 701-2000, Fax (518) 701-2020

Immunotherapy (Allergy Shots) Financial Consent

SCIT: SubCutaneous ImmunoTherapy

Immunotherapy: Preparation of Vials

Your allergy vial(s) are specially prepared in our office and are custom formulated based on the results of your specific allergy skin test.

Please call the billing office if you have any questions about your coverage.

Patient is responsible to advise office when insurance coverage has changed. Patient will be responsible for payment if not covered by changed coverage. 701-2086

_____ I agree to advise the office if my insurance coverage has changed and that I am responsible for any payment not covered by my existing or new insurance coverage.

_____ I agree to start allergy injections, as discussed with my provider, and I agree that my custom vials will be made.

_____ I do not wish to start allergy shots at this time.

Current Insurance: _____

Assignment and Release:

I hereby authorize my insurance benefits to be paid directly to Albany ENT & Allergy Services PC and acknowledge that I am financially responsible for appropriate deductibles, copayments and non-covered items, including those charges which have been denied by my insurance carrier. I understand it is my responsibility to verify that my insurance plan will cover medical services provided by Albany ENT & Allergy Services. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company and health care provider(s) in accordance with HIPPA guidelines.

Patient's Name (print): _____ D.O.B. _____

Patient/Parent/Guardian's Signature: _____

Witness: _____ Date: _____