Consent for Immunotherapy (Allergy Injections)
Authorization for Treatment

I realize that the immunotherapy program requires a commitment of my time. I have been informed that allergy extracts are formulated specifically for me and will eventually outdate. If I have not kept to the prescribed schedule, my serum may expire and have to be re-made at additional cost.

I HAVE REVIEWED THE ATTACHED PRICE LIST, and I understand that if I decide to not start immunotherapy after I have given my consent and after my vials have been made **I AM STILL RESPONSIBLE FOR ALL CHARGES INCURRED.**

I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of immunotherapy, and these questions have been answered to my satisfaction. I understand that precautions consistent with this medical practice will be carried out to protect me from adverse reactions to immunotherapy. I do hereby give consent for the patient designated below to be given immunotherapy (allergy injections) over an extended period of time and at specified intervals, as prescribed. I hereby give authorization and consent for treatment by the Allergy and Asthma Center, P.C., doctors and staff, including authorization and consent for treatment of any reactions that may occur as a result of an immunotherapy injection(s). **If the patient is under 15 years of age, a parent or legal guardian must be present during the waiting period.**

I have been informed that I MUST remain in the office for 30 minutes after each shot—NO EXCEPTIONS.

If you have questions concerning anything in this consent for immunotherapy, please direct the questions to the nurses or to the physician. **If you wish to begin immunotherapy, please sign below.**

_____ _____

Printed Name of Immunotherapy Patient Birth Date

As parent or legal guardian, I understand that I must accompany my child throughout the entire 30-minute wait.

_____ _____

Patient Signature (or Legal Guardian) Date Signed

_____ _____

Witness Date Signed

Please call our office if you do not receive phone call within three (3) weeks notifying you that your bottles are ready and that you can start immunotherapy.

Allergy injections will be given during the following times:

	Eugene Office 330 S. Garden Way #150 Eugene, OR 97401 (541) 485-0316	Corvallis Office 330-C N.W. Elks Dr. Corvallis, OR 97330 (541) 754-7170
Monday	9:00 – 4:30	9:00 – 12:30 2:00 – 4:30
Tuesday	12:00 – 5:30	
Wednesday	9:00 – 11:30 1:30 - 4:30	9:00 – 12:30 2:00 – 4:30
Thursday	12:00 – 5:30	
Friday	9:00 – 4:30	