ALLERGEN IMMUNOTHERAPY SERUM RENEWAL CONSENT

The Pediatric Lung and Allergy Center

Anne C. Miranowski, M.D.
David M. Anmuth, M.D.
2730-A Prosperity Avenue, Fairfax, VA 22031 | 19465 Deerfield Avenue, Suite 410, Leesburg, VA 20176
Telephone (703) 289-1410 Fax (855) 208-6277 TIN#: 54-1110106

Patient name: _____ Date of birth: ____/____/____ Today's date: _____

I authorize The Pediatric Lung Center to prepare:

_____ A dilution of my extracts (insurance may not cover dilutions)

_____ Renewal extracts (extract vials are expiring or running out)

I receive my shots at:

_____ The Pediatric Lung Center

_____ An outside medical office: _____

If you receive your allergy shots at an outside medical office, please have your current allergy shot record faxed to our office at 855-208-6277.

If you wish to continue to have your injections administered at an outside medical facility, please designate your preference below:

□ **Pick up my vials to take them to the outside administering physician**. There is a $15 charge for packaging the extracts to take out. This charge cannot be billed to your insurance company and is due at the time of pick-up. Extracts must be delivered within 4 hours of pick-up to the outside administering medical facility.

□ **Have my vials shipped to the outside administering physician**. There is a $15 charge for packaging the extracts for shipping as well as an overnight shipping charge of $35. These charges cannot be billed to your insurance company and are due before the extracts are shipped. If the destination office is closed on any weekdays and thus unavailable to accept deliveries, please inform our office when submitting this form. If no one is available to sign for the delivery and the extracts are delayed over 24 hours, the extracts will not be safe for use. The patient will be responsible for any extract replacement costs.

Insurance Information:

Person Responsible for Account _____

Relation to Patient _____ Date of Birth _____ Social Security Number _____

Current Insurance Company _____

Group Number _____ Subscriber Number _____

_____ _____
Signature of Patient or Legal Guardian Date Signed