Patient Allergy Testing Documentation

Patient History Report Form

Patient Name: _____ DOB: ____/____/___ Date: ____/____/_____

Patient Insurance: _____

1. Has the patient ever had a severe allergic reaction? Yes No

2. Does the patient have Asthma? Yes No

   If yes, is your asthma controlled? Yes No

3. Has the patient ever been allergy tested? Yes No

4. What allergy medication does the patient take? _____

   _____

Patient/Guardian Signature: _____

Date: ____/____/_____

Allergy Symptom Checklist

Please place a checkmark at each of your symptoms you have experienced within the last 12 months, and return the completed checklist to the allergy tech.

Ears

- ◯ Drainage
- ◯ Ear Aches
- ◯ Ear Infections
- ◯ Hearing Loss
- ◯ Itchy Ears
- ◯ Ringing in Ears

Eyes

- ◯ Blurred Vision
- ◯ Dark Circles
- ◯ Itchy Eyes
- ◯ Sticky Eyelids
- ◯ Swollen Eyes
- ◯ Watery Eyes

Nose

- ◯ Excessive Mucous
- ◯ Hay Fever
- ◯ Sinus Problems
- ◯ Sneezing Attacks
- ◯ Stuffy Nose

Emotions

- ◯ Aggressiveness
- ◯ Anxiety
- ◯ Depression
- ◯ Irritability/Anger
- ◯ Mood Swings
- ◯ Nervousness

Lungs

- ◯ Asthma/Bronchitis
- ◯ Chest Congestion
- ◯ Difficulty Breathing
- ◯ Shortness of Breath
- ◯ Wheezing

Skin

- ◯ Eczema
- ◯ Dermatitis
- ◯ Excessive Sweating
- ◯ Flushing/Hot Flashes
- ◯ Itching
- ◯ Hives/Rashes

Energy & Activity

- ◯ Apathy
- ◯ Fatigue
- ◯ Hyperactivity
- ◯ Lethargy
- ◯ Restlessness
- ◯ Sluggishness

Mouth & Throat

- ◯ Canker Sores
- ◯ Chronic Coughing
- ◯ Gagging
- ◯ Throat Clearing
- ◯ Sore Throat
- ◯ Swollen Tongue/Lips

Head

- ◯ Dizziness
- ◯ Faintness
- ◯ Headaches
- ◯ Insomnia
- ◯ Lightheadedness
- ◯ Migraines

Allergy Testing & Immunotherapy Informed Consent

Patient's Name: _____ Date: ____/____/_____

The following consent is intended to improve communication and education to patients regarding their allergy testing and immunotherapy treatment.

- The diagnosis required for this procedure: **Allergic Rhinitis**
- The nature of this procedure is **Hypo-sensitization**: This is an attempt to reduce sensitivity to what you are allergic to.
- The purpose of these procedures is: **to test for allergies and relieve allergy symptoms.**

I voluntarily agree to receive an allergy test under the supervision of my provider to help determine the cause of my allergy symptoms. Based on the allergy test results, I agree to receive treatment for my allergy symptoms through immunotherapy under the supervision of my provider.

The allergy testing procedure is being performed through a plastic prick device with serum attached to the tip. Each devise is lightly touched on the top layer of the epidermis on the patients back side or the patient's forearms. The test requires 20 minutes for the allergens to react. Each reaction to the prick test is reviewed by the allergy tech. Following the prick test the allergy tech will determine which allergens should be tested through an intradermal skin test. The tech will lightly inject small amounts of each allergen as deemed necessary by the allergy tech to attain a more accurate test result for immunotherapy treatment.

When the allergy test is completed and reviewed, the allergy tech will order the appropriate allergens for immunotherapy treatment. The average patient will be on allergy immunotherapy treatment for a minimum of 1-2 years. Treatment with immunotherapy will be more successful and pose less risk if you are consistent with your allergy shots per the dosage log that is communicated to you by the allergy tech. Possible risks that occur with allergy and immunotherapy treatment include local and mild reactions that are not uncommon. The allergy tech will monitor the size of the reactions and inform the medical staff of any reactions you may experience. Local reactions could include: burning, itching, bleeding, swelling, and redness of skin. There are more severe reactions that are less common but could involve the heart, lungs, blood vessels, swelling of the tongue or throat, shortness of breath or wheezing.

Although these symptoms are rare, we prepare for the possibility of these situations and are equipped to care for the patient's needs.

Serious reactions usually occur within 20 minutes after an injection. **It is for this reason that all patients who receive allergy injections in our office must remain in our designated waiting area for no less than 20 minutes, or until checked by our allergy technician.** If you choose to leave prior to the 20-minute waiting time, you do so against medical advice and therefore accept all responsibility and liability for any subsequent reactions from the shot(s). There is a possibility of a reaction occurring after a patient who receives their injection(s) or skin test, leaves our office. It is vitally important that any such reaction be reported to the allergy technician before receiving the next injection.

I understand that the practice of medicine is not an exact science and that no guarantee or assurances have been made to me concerning the results of the procedure. By signing this form, I acknowledge that I have read, or had this form read to me, and I fully understand its contents. I have been given the opportunity to ask questions and all questions have been answered satisfactorily.

I acknowledge that if I have a reaction greater than the negative control it is considered a positive result on my allergy test. Allergy serums will be prepared to initiate treatment as needed and to be determined by the medical professionals in charge of the allergy testing and treatment. Depending upon the insurance company and the requirement for your doctor to receive payment, the Antigen Therapy Preparation (95165) will be billed for the entire year even though you are not present at the doctor's office. Please understand that you, the patient, cannot be present during the preparation of the antigen therapy. If you have any questions, please discuss with your allergy technician.

I, the undersigned, have read all two (2) pages of this form in its entirety and/or have had this form explained to me and fully understand the contents of this authorization and I request my immunotherapy medication be made. I understand the physician and medical personnel will rely on statements about the patient in determining whether to perform testing and/or treatment for the patient's condition in treatment of their allergies. I understand that the practice of medicine is NOT an exact science, so no guarantee can be made concerning results of the procedure.

Signature of patient or guardian: _____
Printed Name: _____
Dated: ____/____/_____

Signature of Witness: _____
Printed Name of Witness: _____
Dated: ____/____/_____

Communication Consent Form

Patients may elect to receive communications via email, mobile text, and phone regarding personal medical information. By allowing your technician to communicate with you using this method, you can receive appointment alerts as well as immunotherapy updates. Please be assured that all information will be kept confidential. By your signature below, you agree that:

1. You would like to receive Short Message Service (SMS) messages and/or email pertaining to your allergy treatment, including, patient appointment or treatment reminders and other allergy related educational information to assist you in your allergy treatment;
2. You would like to receive a SMS message (as described above) through your communication service provider to deliver the SMS message to the mobile number listed below;
3. Your communication services provider is acting as your agent in this capacity; and
4. You are providing a valid email and/or mobile phone number for these email and/or SMS messaging services.

There are no charges imposed by your provider for SMS message services, but you are responsible for all applicable charges or fees imposed by your communications service provider.

Patient Name: _____

Patient/Guardian Signature: _____

Patient E-Mail Address: _____

Patient Mobile Number: _____

Note: You are not required to provide consent for receipt of email or mobile text messages as a condition of any allergy service or treatment. We may terminate text and/or email messaging services from time to time, for any reason, and without notice. This service is only applicable if your designated allergy technician is participating.

Immunotherapy Record of Acceptance

Patient Name:_____ DOB: ____/____/_____

Based on the results of my allergy test, I can benefit from Immunotherapy. It has been indicated as a benefit of my medical insurance and I request that my Immunotherapy Medication be made. I understand that my insurance will be charged over the course of the next year for the immunotherapy serum, and that I cannot be in the office for this service. I agree to accept an entire year of immunotherapy treatment and serum to be mixed and billed according to my insurance carriers' guidelines.

Patient/Guardian Signature _____
Date____/____/_____

Patients receiving in-office allergy injections must remain in the designated waiting area for no less than 20 minutes or until checked by one of our lab technicians. If you choose to leave prior to the 20-minute waiting time after your injection, you do so against medical advice and therefore accept all responsibility and liability for any subsequent reaction(s) from your allergy shot(s). If a reaction occurs after leaving the provider's office, you understand you must report any such reaction to the provider before receiving the next injection.

Duration of Treatment: The average patient will be on allergy immunotherapy for a minimum of two (2) years. This schedule varies from patient to patient depending on what your allergies are, how severe they are, and how you tolerate treatment. **I understand that my signature below is approval for my provider to discard my immunotherapy medication upon expiration.**

I certify that the statements above are true and correct:(Patient/Guardian Signature):

_____

For office use only:

1. Allergy History was taken and is on file in patient's records
   Yes No
3. Patient has tried over-the-counter and other prescription medications
   Yes No
4. Patient underwent allergy testing; Test was valid and identified an allergen(s).
   Yes No
5. Patient has been informed about risks of Immunotherapy
   Yes No

Supervising Provider's Signature _____

Allergy Eligibility and Benefits

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Primary Insurance

Carrier: _____

Phone: _____

Address: _____

City: _____ State: _____

Member ID: _____

Group Number: _____

Effective Date: _____

Co-Insurance: _____ **%**

Ind. Ded: $ _____ **Met: $** _____

Fam. Ded: $ _____ **Met: $** _____

OOP Amt: $ _____ **Met: $** _____

Representative: _____

Reference Number: _____

Secondary Insurance

Carrier: _____

Phone: _____

Address: _____

City: _____ State: _____

Member ID: _____

Group Number: _____

Effective Date: _____

Co-Insurance: _____ **%**

Ind. Ded: $ _____ **Met: $** _____

Fam. Ded: $ _____ **Met: $** _____

OOP Amt: $ _____ **Met: $** _____

Representative: _____

Reference Number: _____

95004 – Allergy Test

Benefits w/Office Visit: _____

Benefits w/out Office Visit: _____

Pre-Auth Required: _____ Pre-Auth #: _____

95165 – Mixing Meds

Benefits w/Office Visit: _____

Benefits w/out Office Visit: _____

Pre-Auth Required: _____ Pre-Auth #: _____

95115 & 95117 – Allergy Injection

Are these codes covered: _____ Is there a patient co-pay: $_____%_____

Patient Agreement/Contract

The Allergy Test and Immunotherapy eligibility and benefit information has been explained to me. I acknowledge that if I have a reaction greater than the negative control, it is considered a positive result on my allergy test. Allergy Serums will be ordered to initiate treatment, as needed, and to be determined by the Provider. Depending on the insurance company and their requirement for your doctor to receive payment, the Antigen Therapy Preparation (95165) will be billed over the course of the next year for the full years' worth of allergy serums, even though you are not present at the doctor's office. Please understand that you, the patient, cannot be present during the preparation of the Antigen Therapy. If you have any questions, please discuss with your Allergy Technician.

I, the undersigned, have read all two (2) pages of this form in its entirety and/or have had this form explained to me and fully understand the contents of this authorization and I request my Immunotherapy medication be made as needed.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT THESE BENEFITS ARE AN ESTIMATE AND NOT A GURANTEE OF PAYMENT.

Print Name: _____Patient/Guardian Signature: _____

Date: ____/____/_____ Allergy Tech Signature: _____

Immunotherapy Instructional Document

Proper Storage of Medication:

Immunotherapy vials: must be stored in a refrigerator. These vials should NEVER be frozen. Your allergy Technician will monitor your vials of medication throughout your treatment for proper storage.

Epi Pen: This needs to be stored at room temperature.

Antihistamine Therapy

It is highly recommended that patients continue taking antihistamines 2-4 hours prior to their immunotherapy injections for the first 6 months of treatment. This can help patients minimize any allergy symptoms that may occur. It is best to take a long acting antihistamine like Claritin, Zyrtec or Allegra.

PATIENTS CANNOT RECEIVE AN INJECTION IF THEY HAVE:

- a fever of 101 or greater.
- A sinus infection
- Recently prescribed antibiotics
- Difficulty breathing
- Asthma symptoms
- Become pregnant

If any of the above listed pertain to you, do not continue treatment until the issue is resolved, or you have consulted with your medical provider or allergy technician.

Safety Information:

You MUST keep your Epi Pen on hand for at least 3 hours after every injection.

Do not exercise 2 hours before or after your immunotherapy injections are administered.

Do not go to sleep at least 3 hours after every injection has been administered.

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Remember possible side effects and adverse reactions can occur when giving yourself immunotherapy injections. It is important to know these reactions and how to treat mild and sever reactions. Please contact your allergy technician if any of the following mild reactions continue longer than 48 hours.

Mild Reactions:

1. Itching at the injection site
2. Redness at the injection site
3. Swelling at the injection site
4. Allergy symptoms

These symptoms can be treated with Benadryl and an ice pack. Be sure to place a towel between the ice pack and the skin when icing the site. This is not a complete list of all reactions that can occur.

Severe Reactions:

1. Shortness of breath/Wheezing
2. Tongue swelling
3. Throat swelling
4. Difficulty breathing

These symptoms should be treated with an Epi Pen Auto Injector as directed. Once the Epi Pen has been used, the patient MUST call 911 or have someone take them to the ER. Do not discard the Epi Pen. Once 911 has been called take a dosage of liquid Benadryl per the instructions recommended on the Benadryl bottle. Even if you feel your symptoms have been relieved from the Epi Pen and the Benadryl the patient MUST still be seen at the ER, delayed reactions are always a possibility. IF after the initial use of the Epi pen, the patient sees no sign of relief, after 5-15 minutes the patient may administer the second Epi Pen in the other leg.

The symptoms listed above are NOT a complete list of all reactions that can occur, but they are the most common.

I have been educated on the information in this welcome packet. I fully understand the information and accept responsibility of the information in this packet and waive any claims of liability against my provider and Elite Allergy Services.

_____ _____/___/___ _____ _____/___/___

Patient/Guardian Signature **Date** **Allergy Technician Signature** **Date**