



Northern Colorado
Allergy & Asthma
 Clinic, LLC

Fort Collins Office
 970-221-2370
 970-221-9654(fax)

Greeley Office
 970-330-5391
 970-330-5392(fax)

ANTIGEN PREPARATION RELEASE

PATIENT NAME: _____

I have discussed allergy injection therapy with the physician, and understand what it involves. I am also aware that my antigens are to be made in your office by a trained staff member, and should be ready in approximately 2 weeks.

By signing this form, I am acknowledging the fact that the antigens are to be made and billed to my account. If I am unsure of my decision for any reason, I will sign this form once I have made my final decision.

These charges will remain on the account should I choose not to proceed with the injections at a later date.

I hereby authorize the Northern Colorado Allergy & Asthma Clinic to prepare my antigen.

Patient or Guardian Signature	Date
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Witness Signature

Injections will be administered by:

- Northern Colorado Allergy & Asthma Clinic**
 - Ft. Collins**
 - Greeley**
 - Loveland**
 - _____

Other physician office – ADDRESS:

INFORMED CONSENT FOR ALLERGY INJECTION THERAPY

I have reviewed the allergy injection therapy information provided by the Northern Colorado Allergy and Asthma Clinic, LLC and am acquainted with the indications (reasons) for this therapy. I recognize that no guarantee has been made that this therapy will result in a cure or resolution of my symptoms.

I understand that allergy immunotherapy does not take the place of avoidance of allergens to which I am known to be sensitive and that the overall effectiveness of this injection treatment program also depends on my compliance with recommendations with respect to environmental control, dietary restrictions, and the use of medications. ***I understand allergy injection therapy generally takes 6-12 months before benefit is noted and that improvement thereafter may be gradual.***

I understand that allergy injections should be administered under the supervision of a physician. ***HOME INJECTIONS ARE NOT PERMITTED.*** I am required to be observed for at least 30 minutes following an allergy injection in a medical setting and understand that I must report any problems which I might recognize resulting from an allergy shot to the staff of this office before receiving any additional allergy injections.

I recognize that it is important to understand that whenever anyone is exposed to a substance he/she is sensitive to, the possibility of a generalized reaction (anaphylaxis) including shock, and even death, exists. Although rare, a few such cases have occurred. This is also true for any drug administration such as Penicillin or any other foreign substance.

I understand that I may withdraw from allergy injection therapy at any time without prejudice to continue on allergy therapy. I will make myself available for periodic assessment of my clinical condition in order to determine if the therapy should be continued or altered. I have been allowed to ask questions about this procedure. In addition, I have read this form and it has been explained to me. I understand the risks involved and intend to undergo allergy injection therapy.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THIS THERAPY, ASK THEM BEFORE SIGNING THIS FORM.

Patient or Guardian Signature

Date

Witness