Boise Valley
Asthma & Allergy
Clinic

JOHN D. JEPPSON M.D., MICHAEL V. KEILEY M.D., G. WILLIAM PALMER M.D.,
HEIDI PETERS, FNP., JENNIFER NEUMAYER, NP-C

Patient Name: _____

I have discussed my insurance and payment information with the business staff at Boise Valley Asthma and Allergy Clinic regarding the charges for allergy extract and injections. I authorize Boise Valley Asthma and Allergy Clinic to order and prepare my allergy extract and understand my account will be charged and insurance filed for these vials.

I further understand that the final responsibility for the payment of these charges is mine. I understand that the allergy extract is being prepared specifically for me and that if I decide not to start or to discontinue allergy immunotherapy, I may still be responsible for the charges. I further understand that my insurance may not cover allergy extract prepared for me which I decide not to use. I also understand that unexpected reactions or interruptions in my injection schedule may result in the expiration of certain vials, causing them to be remade and those additional charges then added to my account.

With this knowledge I request the vials be ordered and prepared for me and I consent to any necessary treatment required in the event of any injection reaction.

I agree to start immunotherapy treatment and I accept financial responsibility for the allergen extract, which will be prepared and billed upon my signed consent. I understand there will be a **recurring charge** (6-12 months) for the allergy extract. There will also be a charge for the administration of the injection(s) on each visit.

_____ _____
Signature of Patient or Parent/Guardian Date

February 1, 2015