Stanford HEALTH CARE
STANFORD MEDICINE

(Patient Label)

CONSENT FOR ANTIGEN PREPARATION AND TREATMENT

Every insurance carrier varies in reimbursement for allergy shots, and coverage policies may vary from year to year. We recommend you contact your insurance carrier directly regarding coverage and out-of-pocket expenses. Once you have authorized Menlo Medical Clinic Allergy Department to mix your antigen extracts, you are financially responsible for the cost of the extracts.

Below are the billing codes used for allergy shots for insurance reimbursement purposes. Please note, costs may vary based on the number of injections you will receive, as well as the type of injections. If you are unsure of which billing code will be used, please consult with our allergy shot nurse.

INJECTION ADMINISTRATION	**Code: 95115 or 95117**
EXTRACTS (SERUM)	**Code: 95165**
VENOM EXTRACTS (SERUM)	**Code: 95145, 95146, 95147, 95148 and/or 95149**

I UNDERSTAND:

- **The risks and benefits of immunotherapy "allergy shots".**
- **Risks including mild to severe allergic reactions including anaphylactic shock.**
- **Long-term commitment; need for weekly injections for at least the first 6 months.**
- **I will need to schedule annual follow up appointments with my physician.**
- **I must wait 30 minutes in waiting room after receiving my shots.**
- **In the event of anaphylaxis, I accept emergency treatment deemed necessary by a physician**
- **If the patient is a minor, specifically 13 years of age or less, the patient must be accompanied by a responsible adult.**

By signing this form, I authorize Menlo Medical Clinic, Allergy Department to prepare antigens for allergy injections. I have submitted my correct insurance information to Menlo Medical Clinic. I understand that my insurance will be billed for this service and agree to financial responsibility for costs that are not covered by my insurance. If at any time I choose to discontinue my allergy injections, I agree to notify the Menlo Medical Clinic Allergy Department immediately.

Patient signature: _____ Date: _____

Patient printed name: _____

Parent or Legal Guardian's signature
(if patient is a minor) _____ Date: _____

Parent or Legal Guardian's printed name: _____

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