Revere Health Allergy & Immunology

Henry Yeates, MD • Tammy Jacobs, MD

(Office Only) MRN: _____

PATIENT NAME: _____

DOB: ___/___/_____ **AGE:** _____ **SEX: M / F**

DECLARATION OF INTENT TO BEGIN IMMUNOTHERAPY

DATE: ____/____/_____

Immunotherapy is a common treatment indicated for allergic rhinitis (hayfever) and asthma. My physician has explained the risks and benefits regarding immunotherapy, and has recommended this treatment for me or my child. I understand that immunotherapy is a series of injections (subcutaneous immunotherapy or SCIT, allergy shots) or a series of drops (sublingual immunotherapy or SLIT, allergy drops) that may or may not be covered by my insurance. It is my responsibility to verify coverage with my insurance.

At this time I would like to begin, or would like my child to begin immunotherapy. I understand that ALL injections will need to be administered in a physician's office.

Provider (circle one)**: Henry Yeates, MD / Tammy Jacobs, MD**

Please circle one: SCIT (allergy shots) SLIT (allergy drops)

Serum:	**SCIT (shots) CPT code: 95165**	**SLIT (drops, NOT COVERED BY INSURANCE)**
One vial:	$280	$95 per month
Two vials:	$560	$190 per month
Three vials:	$840	$285 per month

We will bill this cost to your insurance company, unless you're choosing SLIT. The serum expires after one year. If you come in as directed, you'll run out of serum in approximately 4 months for injections, and 1 month for SLIT.

SCIT (Allergy Shots – CPT code: 95115 or 95117): This is the cost for the administration of the injection. It will be billed to your insurance.

One injection:	$25
Two or three injections:	$32

SLIT (Allergy Drops): You will only have the cost of the allergy serum. It will need to be refilled more often than with allergy injections. SLIT is not covered by any insurance. SLIT cannot be billed to your insurance company.

***** Please call your insurance company to find out how they will cover allergy injections and allergy serum. SLIT is not a covered benefit; therefore, you will be responsible for the cost.**

If you plan obtain your injections at another physician office (otherwise leave blank):

Delivery:

☐ Office Pick-up ☐ Mail Out to ($10 S&H): _____

Accepting Physician Address

☐ **Please provide the ALLERGY SHOT RELEASE FORM to your accepting physician for them to review, sign and fax to our office.**

***** You MUST take an antihistamine at least one hour prior to your allergy injection.**

***** FOR YOUR SAFETY: In the unlikely chance that you have a reaction, you may be treated in a neighboring Urgent Care facility or physician with subsequent charges from that physician or department. If the reaction is severe or life-threatening, you may be transported to the nearest Emergency Department with subsequent charges from that department.**

Signature: _____ **Date:** _____/_____/_____

Phone: (_____**)** _____**-**_____