Pinnacle Allergy

ALLERGEN IMMUNOTHERAPY PATIENT CONSENT FORM

Immunotherapy, hyposensitization, or allergy injections should be administered at a medical facility with a medical physician present since occasional reactions may require immediate therapy. These reactions may consist of any or all the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; coughing; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the last under extreme conditions. Reactions, even though unusual, can be serious and rarely, fatal. You are required to wait in the medical facility in which you receive the injections for 30 minutes after each injection. If the patient is 17 years of age or younger, a parent or legal guardian must be present during the waiting period. I verify that I (or patient) am not taking beta blocker medications or that if I am, I have discussed the risks/benefits of doing so with my physician (see information sheet).

I have read (if new patient) or re-read (if established patient) the patient information sheet on immunotherapy and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of immunotherapy and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions. I also agree that if I have an allergic reaction to the injections that the physician-in-charge has permission to treat said reaction.

I acknowledge the fact with my signature that I am authorizing the office to bill for allergen vaccines, even if, for any reason, I decide not to initiate the allergen immunotherapy program after the vaccine has been made. Vaccines may be prepared up to 1½ weeks prior to my appointment. I agree to obtain prior authorization, if needed, from my insurance plan.

PATIENT_____ DATE _____

PARENT or LEGAL GUARDIAN_____ DATE _____

As parent or legal guardian, I understand that I must accompany my child throughout the entire **20**-minute wait.

Provider _____ DATE_____

New start SCIT_____ SLIT _____

Maintenance refill Vial # ___ A | B | C

Updated 3/21/2022

MEDICAL RECORDS & FMLA REQUEST FEE

BURSON ENT

2080 Newnan Crossing Blvd

Suite 200

Newnan, GA 30265

Patient Name:_____DOB:_____

MEDICAL RECORDS REQUEST FEE

The office of **James G. Burson , M.D.** will provide your records to you once you have completed the Patient Authorization for Use/Disclosure of Protected Health Information (PHI) form. In order to comply with federal laws including HIPAA, as well as Georgia federal statutes, this office must have a signed authorization from the patient / responsible party stating who we are authorized to release information to. **Please be sure to sign the form below. Unsigned requests cannot be processed.**

Your request will be processed and fulfilled within 30 working days. We will either mail or fax the Records to the information you provide on the authorization form.

Listed below are the charges for copying medical records:

Search/ Retrieval	$25.88
Pages 1 – 20	.97 per page
Pages 21-50	.83 Per Page
Pages 51 or more	.66 Per Page

FORM AND LETTER FEE

This is to notify you that the office of James G. Burson , M.D., will apply a fee of $50.00 to your account for patients, companies, family members, insurance carriers or other people requesting form /or letters to be completed.

Forms include, but not limited to **FMLA**, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, ect. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, gyms, ect.

Signature of patient or responsible party

_____DATE:_____

Revised 10/22