Allergycare365

Sublingual Immunotherapy Consent and Financial Waiver

Today's Date:____________________________

Patients Name:____________________________________ DOB:______________

Sublingual Immunotherapy (allergy drops) is an off-label treatment using FDA-approved antigens and is a self-pay treatment option. Our practice will submit claims for all services to your insurance company, including but not limited to office visits and testing procedures. Sublingual Immunotherapy is not covered by insurance.

Your custom Sublingual Immunotherapy Prescription cost will be collected directly by Alabama Allergy & Asthma Center at a cost of $150.00 (shipping charges included) per month. Patients are required to have a direct bill credit card on file with our practice for this service.

All prescriptions will be automatically refilled every 90 days and mailed conveniently to your address on file with our practice. If you choose to cancel this service, you can do so at any time by emailing your request to AC365@alabamaallergy.com. Refills can be canceled up to 30 days prior to your next refill date. Patients who cancel from the program will require an office visit to be restarted with our program at a future date.

Please sign and date acknowledging you have read and agree to our financial policy and consent to sublingual immunotherapy treatment. We look forward to partnering with you in your immunotherapy care.

Name:____ ____________

Patient, Parent or Legal Representative Signature/Relationship to Patient Date

Please return this form to AC365@alabamaallergy.com or by fax to 205-870-1621

For more information, email AC365@alabamaallergy.com or call 205-871-9661and press 1.

Please note, email is not a secure method of communication

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information Form

Patient Account #:____
Card Type: ☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **AMEX** ☐ **Other**____
Cardholder Name (as shown on card):____
Card Number: ____
Expiration Date (mm/yy): ____
Cardholder ZIP code (from credit card billing address): _______________________________________

I, ________________________________, authorize _________________________ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

____ ____

Customer Signature Date

Please return this form to AC365@alabamaallergy.com or by fax to 205-870-1621 For more information, email AC365@alabamaallergy.com or call 205-871-9661 and press 1.

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