FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.
ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
DIPLOMATES OF THE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

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AUTHORIZATION FOR VENOM IMMUNOTHERAPY

Your signature indicates that you have read this statement and that it is your intent to go forward with venom injections.

Name: _____DOB _____MR# _____

Location: _____

It has been recommended and I agree to start receiving venom injections at Fairfield County Allergy, Asthma & Immunology Associates.

I understand I will be fully responsible for all deductibles, co-pays, etc., and it is my responsibility, not the responsibility of FCAAIA to determine my insurance coverage.

Please call our business office at (203)663-2236 should you have any concerns regarding charges.

Please allow two weeks for the preparation prior to your appointment date. We strongly recommend contacting the office a day or two prior to your appointment to confirm that your venom extract is ready for you to start.

***We must receive this completed form and a copy of your insurance card before we can prepare your venom.**

Signing acknowledges the receipt of Venom Guidelines & Information, approval of the policy holder if different than the patient or parent/guardian, as well as, the financial responsibility of the policy holder/guarantor.

Signature _____Date _____

Printed name _____Date _____
(**Parent/Guardian, if minor**)

Signature _____Date _____
(**Parent/Guardian, if minor**)

Authforvenomimm/wpdata/stdform