FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSOCIATES, P.C.
ADULT AND PEDIATRIC ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY
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AUTHORIZATION FOR ALLERGY EXTRACTS

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

Name: DOB: MR#: Location:

It has been recommended and I agree to start or continue receiving my allergy injections for at least one year.

These extracts are being mixed solely for my use and should be considered an individualized prescription based on my specific skin test results. Billing for one year's supply of allergy extracts (allergy vaccine) will occur when the vials are prepared. I understand I will be fully responsible for all deductibles, co-pays, charges in excess of my benefit limits, etc., and it is my responsibility, not the responsibility of FCAAIA to determine my insurance coverage. I also understand that if an additional replacement extract supply needs to be prepared, for example, if I am non-adherent with the allergy shot schedule or take my vials out of the office and lose them, damage them, etc., FCAAIA reserves the right to bill me directly for these additional extracts. Payment plan options are available (including financing). Please call our business office at (203)-663-2236.

Please allow two weeks for the preparation prior to your appointment date. We strongly recommend that you contact the office a day or two prior to your appointment to confirm that your vials are available.

***We must receive this completed form and a copy of your insurance card before we can prepare your extract vials. When mixing new vials for expired extract vials, please be aware that because of insurance company requirements, we may be unable to prepare your new extracts prior to at least 1 year and 1 day from the date of their last preparation.**

Signing acknowledges the receipt of Allergy Injection 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)

Revised Authorization For Allergy Extracts 1/26/24