FAIRFIELD COUNTY ALLERGY, ASTHMA & IMMUNOLOGY ASSSOCIATES, 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 and understand this statement and that it is your intent to go forward with allergy injections (Immunotherapy).

Name: _____ DOB _____ Account # _____ Location: _____

It has been recommended and I agree to start or continue receiving 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. This is a non-refundable charge. Billing for a one year supply of Allergy Extract will occur when the vials are prepared. I understand I will be fully responsible for all non-covered charges, deductibles, co-pays, etc., and it is my responsibility, not the responsibility of FCAAIA to determine my insurance coverage. Payment options are available. Please call our business office at (203)663-2236.

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 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 replacement vials for expired extract vials, please be aware that because of new 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 receipt of Allergy Injection Guidelines & Information as well as the financial responsibility of the guarantor.

Print Name _____

Print Child's Name_____ Relationship _____
If Applicable

Signature _____ Date _____
(Parent/Guardian, if minor)
FCAAIA Employee Witness_____ Date _____