Provo Allergy & Asthma Clinic
745 N 500 W Provo, UT 84601
www.provoallergy.com
PHONE: (801) 375-9292 FAX: (801) 375-9290
Evan J. Matheson, MD Christopher L. Gordon, DO

INFORMED CONSENT FOR ALLERGY SERUM

- I UNDERSTAND THAT MY ALLERGY EXTRACTS WILL BE EXPIRING/DEPLETED IN THE NEXT 30 DAYS.
- I UNDERSTAND THAT IF MY INSURANCE INFORMATION IS NOT UP TO DATE, I MAY BE RESPONSIBLE FOR THE ENTIRE BALANCE.
- I UNDERSTAND THAT IF MY INSURANCE WILL BE BILLED AND I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAY, AND/OR CO-INSURANCE THAT IS DEEMED MY RESPONSIBILITY AFTER INSURANCE PROCESSING.
- I UNDERSTAND THAT ALLERGY SERUMS ARE INDIVIDUALLY PRESCRIBED OR CUSTOMIZED FOR ME (PATIENT) AND CAN ONLY BE USED BY ME (PATIENT).
- I UNDERTAND THAT I (PATIENT) MUST SEE MY PROVIDER AT LEAST ANNUALLY TO CONTINUE ALLERGY IMMUNOTHERAPY.
- I UNDERSTAND THAT BY SIGNING THE INFORMED CONSENT THAT I GIVE PERMISSION FOR PROVO ALLERGY AND ASTHMA CLINIC STAFF TO PREPARE A REFILL OF MY ALLERGY SERUM.

PRINT PATIENT NAME: _____ DOB: _____

X_____ DATE: _____

BELOW FOR OFFICE USE ONLY**********

Special Instructions: _____

*****This consent form is only valid for 30 days*****