



City Allergy

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Allergen Immunotherapy Consent Form

Section 1: Consent for Allergy Immunotherapy

I, _____ (**Patient/Guardian Name**), **Date of Birth:** _____ hereby consent to receive Allergen Immunotherapy (AIT) as recommended by my provider in order to reduce allergic sensitivities. This treatment will be based on my individualized formulation determined by allergy testing results.

Section 2: Understanding of Risks, Benefits, and Alternatives

_____ (**Initials**) **1. Purpose and Goals:**

The goal of Allergen Immunotherapy (AIT) is to reduce—and in some cases eliminate—symptoms caused by allergens (e.g., pollen, grasses, dust mites, animal dander, insect venom). Treatment may also reduce medication use and improve quality of life. For optimal success, I understand I must follow the treatment schedule outlined by my provider.

_____ (**Initials**) **2. Risks and Side Effects:**

Our practice uses a cautious and evidence-based approach to AIT. However, as with all medical treatments, there are potential risks:

- **Local Reactions:** Redness, swelling, or itching at the injection site.
- **Systemic Reactions (Anaphylaxis):** These may range from mild symptoms (sneezing, nasal congestion, hives) to more severe symptoms such as wheezing, shortness of breath, or gastrointestinal issues. In rare cases, reactions may be life-threatening and require emergency medical care.

_____ (**Initials**) **3. Monitoring Requirement:**

I understand that I must remain in the office after receiving my injections **for observation in order to monitor for any immediate adverse reactions:**

- For regular AIT injections, I must stay for a minimum of 30 minutes.
- For Cluster AIT protocols, I must remain in the office for at least 40 minutes after the final injection.

If I am unable to stay for the required observation time, my injection(s) WILL BE postponed to ensure my safety.

_____ (Initials) **4. Early Departure:**

If I choose to leave the office prior to completing the required post-injection observation period, I understand that I am leaving against medical advice (AMA). **I have been advised of the risks, including delayed systemic allergic reactions and potentially life-threatening anaphylaxis.** Despite this, if I voluntarily decline continued medical supervision, I accept full personal responsibility for any consequences that may occur after I leave. I acknowledge that this decision may result in the discontinuation of my allergy immunotherapy treatment due to safety concerns. I further understand and agree that the providers and practice are not responsible for any medical events or outcomes that occur following my early departure. This form and AMA acknowledgment may be used as documentation of informed refusal in accordance with New York State medical and legal standards.

_____ (Initials) **5. Alternatives to AIT:**

Alternatives to allergy shots include avoiding known allergens and/or using medications such as antihistamines, decongestants, and nasal corticosteroids.

_____ (Initials) **6. Pregnancy:**

I agree to notify my provider if I am pregnant or become pregnant during the course of treatment.

Section 3: Patient Responsibilities

I understand and agree that:

- I must report any symptoms I experience after receiving my shots—whether mild or severe.
- I must inform my provider of any changes in my health status or new medications prior to receiving further injections.
- I agree to attend all scheduled appointments and adhere to the immunotherapy schedule. I understand that missing appointments may delay the effectiveness of my treatment.

Section 4: Financial Responsibility and Acknowledgement

I acknowledge that once I consent to begin AIT, my personalized treatment vials will be prepared using prescription allergen extracts. These vials and injection visits may be subject to deductibles, co-insurance, and/or copayments as per my insurance policy. I understand that I am financially responsible for **any** portion not covered by insurance.

Section 5: Signature and Acknowledgment

By signing below, I confirm that I have read and understood all sections of this consent form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction, **and I agree to proceed with Allergen Immunotherapy (AIT).**

Patient/Guardian Signature: _____

Patient name (if signed by guardian): _____

Date: _____

Provider/Witness Signature: _____

Date: _____