Patient Consent Form

The Allergy Center at Brookstone
FAMILY ALLERGY & ASTHMA CARE

✓ I have received a copy of The Allergy Center at Brookstone's Patient Handbook containing the Notice of Privacy Practice and the Financial Policy. I understand that I can request additional copies of this information at any time. An up to date copy of the privacy policy is posted in the lobby at all times.

✓ I understand that I will be held financially responsible for all copays, co-insurance, deductibles, and non-covered charges for services performed. I understand I will be allowed 90 days to pay all balances in full that were not paid on the date of service.

I hereby assign my insurance benefits to be paid directly to the physician who renders services or this facility. I understand that if I fail to submit valid and current information for my primary or secondary insurance that I'll be billed at the non-contracted rate.

✓ I authorize my health care provider to use an automated system to contact me or any third parties that may answer my phone to notify me of a pending appointment, and to leave the appointment details on the voicemail of the contact information below. All appointments that are not canceled with a 24 hour notice are subject to a $25 no show/same day cancellation fee.

✓ At my request, I authorize The Allergy Center at Brookstone to communicate detailed protected patient health information (lab results, prescription refill information, etc.) to me using any of the methods listed on the form at the bottom of this page.

Allergy Testing Consent: Your doctor may order an allergy skin test during your visit. Testing consists of introducing small amounts of suspected allergens into the skin on the arms or back and noting the development of a reaction. A positive reaction is noted when the allergen placed on the skin causes swelling/redness. The results are read 15-20 minutes after the application of the allergen. Interpretation of the skin test requires the allergist's skill in matching the test results with the patient history of allergy-like symptoms. If you have taken any antihistamines within 5 days we won't be able to perform an allergy skin test.

✓ If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy area (caused by the release of histamine and other substances into the skin) will appear within 15-20 minutes. These positive reactions will gradually disappear over a period of 30-60 minutes, and typically, no treatment is necessary for positive reactions that occur. Occasionally local swelling at the test site will begin 4 to 8 hours after the skin tests are applied, particularly where the intradermal testing was performed. These reactions are not serious and will begin to disappear over the next week or so. They should be measured and reported to your physician at your next visit.

Skin testing will be administered with a physician present since occasional reactions may require immediate therapy. These reactions may consist of any of the following symptoms: itchy eyes, nose, or throat; congestion, runny nose; tightness in throat or chest; wheezing; lightheadedness; faintness; nausea; vomiting; hives; generalized itching and shock in extreme circumstances.

Identifying the allergy causing agent is only the first step in helping you manage your allergy symptoms most effectively. After skin testing, you will meet with your physician who will make further recommendations regarding your treatment.

✓ I understand that by signing the form below I agree with all of the statements and policies discussed on this consent and that if I have any questions I can request to speak to the office manager, Teresa Heath. I am also signing to indicate that I understand the risks and benefits of allergy skin testing. The opportunity has been provided me to ask any questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that if my Allergist recommends skin testing for me today or in the future, I consent to being testing.

Printed Name of Patient	Patient's DOB	E-Mail

Home Phone	Cell Phone	Work Phone

Signature of Patient / Parent / Legal Guardian	Relationship to Patient (ex – self, parent, etc.)	Today's Date

At my request, I authorize The Allergy Center at Brookstone to disclose my protected health information to the friends or relatives listed below.
If the patient is less than 18 years old, then this section is required.

Name of Authorized Contact #1		Name of Authorized Contact #2	
Relationship to Patient	Phone Number	Relationship to Patient	Phone Number