Triangle Allergy & Asthma, P.A.

135 Parkway Office Court
Suite 100
Cary, NC 27518

Padmaja R. Gayam, M.D.
Board Certified in Allergy, Asthma & Immunology
Board Certified in Internal Medicine

8414 Falls of Neuse Rd.
Suite 106
Raleigh, NC 27615

Office: 919.851.2223 www.triangleallergy.com **Fax: 919.851.2291**

IMMUNOTHERAPY CONSENT FORM

Name: _____

DOB: _____

CHART #: _____

Date: _____

_____ I have read the patient information sheet on immunotherapy and understand
INITIAL the risks and benefits.

_____ The opportunity has been provided for me to ask questions regarding
INITIAL immunotherapy and these questions have been answered to my satisfaction.

I, _____, do hereby give consent for an
PRINT PATIENT'S NAME
immunotherapy prescription to be written and an extract to be mixed specifically for me according to the prescription. (Once mixed, it **cannot** be used by another patient).

I understand that I will be notified by either phone or letter when my extract is ready (please allow 4 weeks). At which time, I am to call the allergy clinic—**919.851.2223**—to schedule an appointment to begin my allergy injections.

_____ I understand that **I will be billed for my allergy extract when it is mixed** and
INITIAL will be **personally** liable for the balance, even if my insurance denies payment.

_____
PATIENT'S SIGNATURE DATE