Joann Blessing-Moore M.D
723 Emerson St
Palo Alto, CA 94301
650-688-8480
650-688-8483 FAX

ANTIGEN CONSENT FOR REFILL

Please read and sign this consent form before you return it to us by mail or fax. We will not make antigens without your signed consent. If the patient is a minor, the parent or guardian must sign. If you have not seen Dr. Blessing-Moore in over six months you will need to schedule a follow up appointment. At the appointment Dr. Blessing-Moore will review with you your allergy shots. **Upon receipt of your request, please allow two to four weeks for us to mix the antigen.**

NOTE: Because your antigen is tailored to your specific allergies, a personal supply is made for each patient. Antigens are made in a one year supply and are good for one year from the time they are made. Your insurance company may not cover the cost of a one year supply of antigen. Some insurance companies pay only as the dose is administered. If you chose to discontinue your immunotherapy before all your antigen has been used you will be responsible for the cost of the remaining antigen.

☐ Maintenance vials OR:

Antigen Name:_____ Vial #_____

Antigen Name:_____ Vial #_____

Antigen Name:_____ Vial #_____

Antigen Name:_____ Vial #_____

Antigen Name:_____ Vial #_____

Please make a new supply of the above antigen so that I may continue my allergy shots. I understand that payment is due when the antigen is prepared. I also understand that I am responsible for knowing my insurance coverage, and am aware that my insurance may have a maximum benefit amount per year for antigens and or injections. I know that my insurance will be billed first for my antigen, and that the remaining cost will be billed to me.

Please Print Name_____ D.O.B_____

Patient/ Parent Signature_____ Date_____

Patient Phone# _____