Dallas Allergy & Asthma Center

Physicians Certified by American Board of Allergy and Immunology

EXTRACT VIAL ORDER FORM

NEW PATIENT ESTABLISHED PATIENT

For new patients beginning allergy immunotherapy, an initial set of allergy extract will be prepared. When this set has been used or has expired, the medical assistant will inform you so you may authorize additional allergy extract to be prepared. **At a minimum, you will need to have an office visit with the doctor AT LEAST ONCE A YEAR so that new extract can be ordered and your medications can be refilled**.

I understand that unexpected reactions and interruptions in my injection schedule may result in the expiration of certain vials, causing them to be remade and those additional charges then charged to my account**.** ***I consent to any necessary treatment required in the event of a reaction***.

PLEASE ALLOW UP TO *2 WEEKS* TO HAVE YOUR EXTRACT VIAL APPROVED BY YOUR INSURANCE/PHYSICIAN AND MADE BY OUR SHOT DEPARTMENT

Patient Name: _____ Date of Birth: _____

Current Insurance: _____ Insurance ID # _____

I authorize Dallas Allergy & Asthma Center to order and prepare my allergy extract. I understand my account will be charged and insurance filed for these vials. I am required to provide DAAC with my current insurance care so my extract can be filed accordingly. I understand that I am responsible for all co-pays/co-insurance/deductibles that may be applied in the making of this extract. With this knowledge, I request the vials to be ordered and prepared for me.

(* Required) Signature of Patient/Guardian: _____

Date: _____ Phone # (_____) _____ - _____ Ext: _____

FOR OFFICE USE ONLY

Number of allergy extract vials to be made _____

Date of Last Office Visit _____ Need appt? Yes / No

Primary Insurance _____ Insurance Phone # _____ ID # _____

Insurance Rep _____ Date Verified _____

Injections w/ OV $_____ Injections w/o OV $_____ Extract $_____

Deductible Amt $_____ Deductible Met $_____

Family Ded Amt $ **_____ Family Ded Met $_____**

Coinsurance _____ Pre-Exist Yes / No **Exp Date _____ Referral Required** Yes / No

Verified/Approved By _____ Entered into Rosch by & Date (nurse) _____