Allergy A.R.T.S.

Asthma, Rheumatology Treatment Specialists

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Extract Vial Order Form

☐New Mix ☐Remix ☐Mix Down

As a patient of Allergy A.R.T.S., I have agreed to begin allergy immunotherapy treatment. By signing this Extract Vial Order form, I consent to have my customized allergy serum mixed. The initial set of allergy serum will consist of silver and colored vials. I understand that it is my responsibility to notify Allergy A.R.T.S. if my serum expires and/or if I run out of serum.

I have discussed my eligibility and benefit information regarding allergy serum and injections with an Allergy A.R.T.S. staff member. I understand that my insurance will be filed for all services rendered, and I will be responsible for any balance left unpaid.

Depending on my insurance coverage, I understand that I may have 24 hours, from the time this Extract Vial Order form is signed, to cancel my allergy serum order. By initialing here _____, I waive my right to have 24 hours to cancel this order.

If at any time I need colored vials mixed, I am aware that I must bring or mail my silver vials to Allergy A.R.T.S.
(All serum mailed to Allergy A.R.T.S. must be mailed with "cold packs".)
Please allow 7 to 10 business days for all serum to be mixed.
To start and/or continue immunotherapy treatment, all patients must be seen by an Allergy A.R.T.S. provider at least once per year.

Patient Name (please print): _____ DOB: _____

Phone Number: _____

Required: Date of Last Injection: _____ Color: _____ Dose: _____ Freq: _____

Check the vials that need to be mixed:

☐ Silver ☐ Red ☐ Green ☐ Gold ☐ Blue ☐ Purple

Please Check One (if necessary):

__ P/U Name of adult picking up serum, if not patient: _____

__ Mail ***(A $25.00 fee must be paid prior to shipment. Shipments are typically sent out weekly on Tuesdays. The shipment may take up to 48 hours to be delivered. If you choose to have your serum mailed, it is your responsibility to have an adult present to sign for the shipment. Allergy A.R.T.S. will not be held liable for any loss, damage, delay, non-delivery, misdelivery, misinformation, and/or refused shipment.***

Street Address (Please NO P.O. BOX): _____

_____

_____

_____ _____

Signature of Patient or Guardian Date

For office use only

Primary Insurance _____	Deductible _____
Verified By _____	Deductible Met _____
Date _____	Amount Owed _____ Fed Ex Pd._____
1:50,000 _____	IH Box # _____
Schedule II _____	Call When Ready _____