## Patient Demographics

Patient Name (first): _____ (last) _____ Patient Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Name: _____ Sex (at birth): _____ Preferred Language: _____

Preferred Gender(optional): _____ Preferred Pronouns (optional): _____

Ethnicity (optional): __ Hispanic/Latino __Non-Hispanic/Latino

Race: __ American Indian __ Alaskan Native __ Asian __Black/African American __White
__ Pacific Islander __Native Hawaiian

## Contact Information

Phone: _____ Email: _____

| | |
|---|---|
| __Okay to leave a detailed message<br>__Leave message with name & number ONLY<br>__Leave no message at all | __Okay to email documents containing PHI, i.e. Skin Test results, Lab Results, Education<br>__Not okay to email documents containing PHI |

## Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

## Insurance Information

If you do not have your insurance card on you today, then please email a copy of the front and back of the card to our email listed below. Please state in the email the patient's name and birthday.

appt@ohallergy.com

## Emergency Contact

Medical Information is not released to this person. (However, this person can be the same as you HIPAA Authorized Contact).
Name: _____ Relation to Patient: _____ Phone: _____

## HIPAA Authorization to Discuss Your Medical Information

Indicated below are names of any Person(s) to whom I would like Premier Allergy and Asthma to allow disclosure of Protected Health Information (PHI). (Please specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, bill information, etc. You may indicate "All" if appropriate). I understand that I am not required to list anyone, and I may change this list at any time in writing.

| Name of Contact | Relationship to Patient | Phone number | Type of Information |
|---|---|---|---|
| | | | |
| | | | |

I acknowledge and understand that all the information given on this page is for medical purposes only and is accurate. I understand that if the information above were to change that it is my responsibility to inform Premier Allergy and Asthma of the change.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

## Financial Policy

Thank you for choosing Premier Allergy and Asthma for your health care needs. Our primary mission is to provide our patients with outstanding medical care.

Please note that your clear understanding of our financial policy is important for our professional relationship. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have, and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

**PROOF OF INSURANCE**: All patients must provide proof of insurance and should confirm with staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. (See below for self-pay policy). It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card and to make us aware of any insurance changes. If you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

**COPAYS, DEDUCTIBLES AND CO-INSURANCE**: All copays must be paid prior to the service. Any copay, deductible or co-insurance that is sent to you by mail in a patient statement is expected to be immediately paid upon receipt of that statement. Payment of your copays, deductibles and co-insurance is part of the contract agreement between you and your insurance company. Our failure to collect payment may be a violation of billing compliance and may be considered an act of insurance fraud by your insurance plan.

**NON-COVERED/SPECIALTY SERVICES**: Please be aware that some or perhaps all the services you receive may not be covered or considered reasonable or necessary by your insurance plan**. It is your responsibility to know which services are covered and if you elect to have these services, you will be expected to make a full payment upon receipt of a statement**.

**SELF-PAY**: If you do not have valid health care coverage, you will be considered as self-pay. Our services will be offered at a discounted rate if you are not using any form of insurance towards your services. Payment in full is due at the time of service unless you make other arrangements with our billing department (see below for Patient Payment Plans). You will also be required to maintain credit card information on our secure database for any services that may remain unpaid.

**NON-PAYMENT**: If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise arranged a payment plan in accordance with practice policy. Please be aware that if a balance remains unpaid, we will attempt to charge your patient responsibility to the card stored on file, if unsuccessful we will turn your account over to a collection agency after the 90th day past due.

**PATIENT PAYMENT PLANS**: If your bill is over $150 and you are unable to pay your full bill you may be set up with a payment plan by our billing department. Please contact our billing department to discuss our tiered payment plan amounts. You will be required to provide credit card information that will be kept in our secure database and you will be automatically debited based on the frequency of payment that is determined by you and the billing department. Any account that remains unpaid after the allotted time will be turned over to a collection agency.

**RETURNED CHECKS**: A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment, or closed accounts. After the second occurrence, only cashier's check or credit card payments will be accepted.

**NO SHOW AND CANCELLATION POLICY**: If you fail to cancel your specialty and/or testing appointment 72 hours prior to the time of when the appointment is scheduled you may be subject up to a $100 fee.

**PAYMENT METHODS:** We accept personal checks, MasterCard, Visa, American Express, Discover and FSA cards as payment for services rendered. We will require a credit card to be stored on file with our practice for any remaining patient responsibility after insurance. Payment for services will be due at the appointment unless arrangements have been made with the billing department or a payment plan has been put in place. An estimate for cost can be provided upon request prior to the appointment and/or service.

**TCPA COMPLIANCE AGREEMENT:** I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Premier Allergy and Asthma and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Premier Allergy and Asthma or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Premier Allergy and Asthma and/or their contractors, servicers, debt collection agencies, or agents.

This is an agreement between Premier Allergy and Asthma and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.**

Patient's Name: _____

Responsible Party (if not the patient): _____

Signature of Patient or Responsible Party: _____

Date of Signature: _____

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**A. We Have a Legal Duty to Protect Health Information about You**

Our practice is committed to treating and using personal health information about you responsibly and with the utmost respect for your privacy. In addition to this moral and ethical obligation, there is also a legal obligation to do the same. We are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information" or "PHI" for short. If a breach of PHI occurs that could compromise the privacy or security of your PHI, you will be promptly notified. We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about: your past, present, or future health condition; health care we provide to you; or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice

This notice describes the types of uses and disclosures that we may make and give you some examples. In addition, we may make other uses and disclosures, which occur as a byproduct of the permitted uses and disclosures described in this Notice. If we participate in an "organized health care arrangement" (defined in subsection B 3 below), the providers participating in the "organized health care arrangement" will share PHI with each other, as necessary to carry out treatment, payment or health care operations (defined below) relating to the "organized health care arrangement".
We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

- Posting the revised notice in our offices and on our website (www.PremierAllergyOhio.com); and
- Making copies of the revised notice available upon request.

**B. We may use and disclose PHI about you without your authorization in the following circumstances:**

**1. We may use and disclose PHI about you to provide health care treatment to you.**

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.
EXAMPLE: We may share medical information about you with another health care provider. For example, if you are referred to another doctor, that doctor will need to know if you are allergic to any medication. Similarly, your doctor may share PHI about you with a pharmacy when calling in a prescription.

**2. We may use and disclose PHI about you to obtain payment for services.**

Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of medical information about you with the following:

- A billing company;
- Collection departments or agencies, or attorneys assisting us with collections;
- Insurance companies, health plans, and their agents which provide you coverage;
- Hospital departments that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and
- Consumer reporting agencies (e.g. credit bureaus).

EXAMPLE: Let's say you're in our office for allergy testing. We may need to give your health plan(s) information about your condition, supplies used (such as serum for your test), and services you received (such as spirometry). The information is given to our billing department and your health plan so we can be paid or you can be reimbursed.

**3. We may use and disclose PHI about you for health care operations.**

We may use and disclose PHI in performing business activities, which we call "health care operations". These "heath care operations" allow us to improve the quality of care we provide and reduce health care costs. We may also disclose PHI for the "health care operations" of any "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the care provided by a hospital and the physicians who see patients at the hospital. In addition, we may disclose PHI about you for the "health care operations" of other providers involved in your care to improve the quality, efficiency and cost of their care or to evaluate and improve the performance of their providers. We may use and disclose PHI to business associates. Certain components of our services are preformed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide your PHI to one or more of these business associates who assist us. In all cases, we require these business associates to appropriately safeguard the privacy of your information. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients. For example, we may use PHI about you to develop ways to assist our health care providers and staff in deciding what medical treatment should be provided to others.
- Improving health care and lowering costs for groups of people who have similar health care problems and to help manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives, classes, or new procedures.
- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.
- Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.
- Cooperating with outside organizations that assess the quality of the care we and others provide. These organizations might include government agencies or accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations.
- Assisting various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with applicable laws.
- Conducting business management and general administrative activities related to our organization and the services it provides.
- Resolving grievances within our organization.
- Reviewing activities and using disclosing PHI in the event that we sell our business, property or give control of our business or property to someone else.

**4. We may use and disclose PHI under other circumstances without your authorization or an opportunity to agree or object.**

We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

- When the use and/or disclosure is required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency that is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner for the purposes of identifying you should you die.

- When the use and/or disclosure relates to organ, eye or tissue donation purposes.

When the use and/or disclosure relates to medical research, under certain circumstances, we may disclose PHI about your for medical research.

- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

**5. You can object to certain uses and disclosures.**

Unless you object, we may use or disclose PHI about you in the following circumstances:

- Using our best judgment, we may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

If you would like to object to our use or disclosure of PHI about you in the above or other specific circumstances, please write to our office using the contact information at the end of this Notice.

**6. We may contact you to provide appointment reminders.**

We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

**7. We may contact you with information about treatment, services, products or health care providers.**

We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.
EXAMPLE: If you are diagnosed with a food allergy, we may tell you about nutritional or other counseling services that may be of interest to you.

**ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION**

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing by our office. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures, which were being processed before we received your cancellation
.

**C. You have several rights regarding PHI about you.**

1. You have the right to request restrictions on uses and disclosures of PHI about you.

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures described in subsection B. 4 of the previous section of this Notice. You may request a restriction in writing at the address below.

2. You have the right to request different ways to communicate with you.

You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number or by email. Your request must be in writing. We must accommodate when appropriate reasonable requests. You may request alternative communications by writing to the address listed below.

3. You have the right to see and receive a copy PHI about you, whether it is on paper or electronic.

You have the right to request to see and receive a copy of PHI contained in clinical, billing, and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy of PHI by requesting this in writing at the address listed below.

4. You have the right to request amendment of PHI about you, whether it is on paper or electronic.

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment. You may request an amendment of PHI by writing to the address below.

5. You have the right to a listing of disclosures we have made.

If you ask us in writing, you have the right to receive a written list of certain of our disclosures of PHI about you. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to March 1st 2011). We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or requested by you, or that you authorized
- Occurring as a byproduct of permitted uses and disclosures
- Made to individuals involved in your care, for directory or notification purposes, or for other purposes described in subsection B.5 above
- Allowing by law when the use and/or disclosure relates to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations (please see subsection B.4 above) and
- As part of a limited set of information which does not contain certain information which would identify you

6. You have the right to a copy of this Notice

You have the right to request a paper copy of this Notice at any time by contacting our office. We will provide a copy of this Notice no later than the date you first receive service for us (except for emergency services, and then we will provide the Notice to you as soon as possible).

**D. You may file a complaint about our Privacy Practices**

If you think we have violated your privacy rights, or you want to complain to us about our privacy practices, please contact us in writing in the following manner:

**Premier Allergy and Asthma, LLC**
**Attn: Privacy Officer**
**6565 Perimeter Dr.**
**Dublin, Ohio 43016**

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

**E. Effective Date of this Notice**

**This notice of Privacy Practices is effective on March 06, 2017**

**HIPAA PRIVACY NOTICE CONSENT FORM**

I understand and have been provided with Premier Allergy and Asthma's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. Premier Allergy and Asthma reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form, I acknowledge that I have been afforded the opportunity to consider Premier Allergy and Asthma's Notice of Privacy Practices prior to signing this consent and making healthcare decisions. I agree to and understand I may have my digital photo taken for identification as part of my electronic health record.

**Patient Name: _____**

**Signature of Patient or Legal Guardian: _____**

**Date: _____**

Premier Allergy & Asthma

Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a wheal, swelling, or flare in the surrounding area of redness). The results are read 15 to 20 minutes after the application of the allergen. The skin test methods are:

**Prick** (also known as percutaneous) **Method**: The skin is pricked with a small, plastic device that has been soaking in the allergen. This test is usually performed on your back.

**Intradermal Method**: This method consists of injecting small amounts of an allergen into the superficial layers of the skin. This test is usually performed on your arms and may be performed if the prick skin test is negative.

Interpreting the clinical significance of a skin test requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms. You will be tested for airborne allergens and possibly some foods. The skin test generally takes 45 minutes.

If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. You may be scheduled for skin testing to antibiotics, local anesthetics, venoms, or other biological agents. The same guidelines apply.

Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances.

Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing. Beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment.

I have read the patient information sheet on allergy skin testing and understand it. I understand that the skin test will not be applied until I've had my questions answered by a medical professional. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient Printed Name: _____

Date: _____

Signature of Patient or Legal Guardian: _____

# Medical Records Release

I authorize Premier Allergy and Asthma to request and release medical records and health information to:
Name(s) of physicians you authorize your care to be communicated with:

| | Name of Physician | Name of Practice | Office Phone Number |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |

This request and authorization applies to all of my healthcare information that is pertinent to receiving proper allergy, asthma, and/or immunology treatment.

This document authorizes release and request of information entered into my medical records prior to or within 12 months after the date of my signature. I also understand that it is my responsibility to notify Premier Allergy and Asthma of any changes that I would like made to this form.

**Patient Name:** _____

**Date of Birth:** _____

**Signature of Patient or Legal Guardian:** _____

**Date:** _____

Premier Allergy and Asthma 6565
Perimeter Drive
Dublin, OH 43016
Phone: 614-328-9927
Fax: 614-389-3727

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us via phone. This authorization will remain in effect until cancelled.

I authorize Premier Allergy and Asthma Inc. to charge my credit card on file for the balance of patient responsibility after insurance payments are posted to my account. I understand that my information will be saved on file for future transactions on my account including, but not limited to copays, cancellation fees, and patient responsibility after deductible or co-insurance, and as a self-pay patient. I can opt into receiving reminders via text and email below when a charge is to be processed. I understand that it is my responsibility to update the practice to any changes to my credit card information, address, and phone number as applicable.

**I agree to receive Text/Email notifications; data charges may apply through your carri◯:**
**Are you paying with an FSA/HSA accoun◯**

Patient Name: _____

Legal Guardian Printed Name(if applicable): _____

Signature of Patient or Legal Guardian: _____

Date: _____

**Consent for Treatment of a Minor without a Parent/Legal Guardian Present**

**Minors under 10 years of age**

In order to maintain the safety of our minor patients, all minors under the age of 10 must be accompanied by a parent/legal guardian/designated adult during ALL appointments and allergy shots-for the safety of your child, we are unable to make exceptions to this policy.

____In the event that I cannot accompany my child to their **ALLERGY SHOT**, someone 16 years of age or older may bring my child. I understand that only a parent/legal guardian can accompany them to an ***appointment.***

---

In keeping the convenience of our patients in mind, with the consent below signed, patients 10 years of age and older may get allergy shots in our office without an adult present. If your child is 16 years of age or older, they may come to their allergy shots **AND** appointments alone with your signed consent. Rush and Cluster therapy are considered appointments.

**Minors 10 years of age and older**

____I authorize the staff of Premier Allergy to treat the minor named below for an allergy shot without my presence. I understand that I will still need to accompany them to an appointment if they are under the age of 16.

**Minors 16 years of age and older**

____I authorize the staff at Premier Allergy to treat the minor named below without my presence for allergy shots and office visits/appointments. They may also make financial and medical decisions without my presence.

***By signing below, I also give my permission that in the event of a life-threatening reaction, the staff at Premier Allergy may treat the below named patient as deemed medically necessary.***

**Patient Name: _____Patient Date of Birth: _____**

**Signature of**
**Parent or Legal Guardian:_____Date:_____**