CONNECTICUT, EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C.
ALLERGY DEPARTMENT

CONSENT FOR ALLERGY TESTING

I, the undersigned, give permission to the testing physicians and nurses to perform allergy testing.

Allergy testing involves the injection into my body of very small amounts of substances to which I may be allergic. I fully understand that severe reactions are extremely rare from allergy testing, but can occur.

I further authorize the physician/nurse to do whatever may be necessary in the event of a serious allergic reaction.

If any healthcare worker becomes exposed to my blood or body fluids during treatment or testing, I agree to have a blood test to check for infectious diseases including Hepatitis and HIV (the AIDS virus).

By signing below, I certify that the nature and purpose of allergy testing has been explained to me, that all alternatives to the testing have been discussed with me, and that I wish to proceed with allergy testing.

If you have Connecticare as your sole insurance, please be aware that you will be responsible for an out-of-pocket fee of:

Allergy Testing- $150
Allergy Testing w/ Food or Inhalant Testing- $300

Please sign at the time of appointment.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

IMPORTANT NOTE: CANCELLATIONS MUST BE RECEIVED DURING OUR BUSINESS HOURS AT LEAST 36 HOURS PRIOR TO TESTING OR YOU WILL BE CHARGED A $35.00 FEE.

Patient's initials _____

Rev. 4/10