105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

INFORMED CONSENT FOR ALLERGY SERUM

I am aware that by signing the informed consent for allergy immunotherapy, Piedmont Pediatrics, LLC will mix my allergy serum **immediately,** and I will be responsible for any balance not covered by my insurance. I understand that these serums are individually prescribed or customized for me and can only be used for my treatment once mixed.

X____/___/________________

Patient Signature (Parent if patient is a minor) Date

Below For Office Use Only ==

_______________________________ ______/_____/_____ _________________________

Print Patient Name **Date of Birth** **Account Number**

_____/_____/_______ ______:______**am/pm**

Appointment Date **Time**

Special Instructions: ____