

# *Richmond Allergy and Asthma Specialists, P.C.*

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## ALLERGY VACCINE WAIVER

Dear Patient,

**Allergy vaccine may or may not be a covered benefit through your insurance plan. In some instances, allergy vaccine may be a covered benefit but there may be limitations on the amount of vaccine that can be made in a given benefit year. It is your responsibility to check the benefits and any limitations on your plan. Allergy vaccine may be subject to your deductible or co-insurance. Co-insurance is the percentage of costs of a covered health care service you pay after the deductible is met. Upon request, the amount that will be billed to your insurance company for each vaccine order will be communicated.**

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Service: Allergy vaccine for your benefit year

***Signing this form acknowledges that you are aware that amounts not paid by your insurance for your allergy vaccine will be your responsibility.***

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Please initial one of the following:  
\_\_\_\_ I received a copy of this form.  
\_\_\_\_ I declined a copy of this form.