ALLERGY AND ASTHMA CONSULTANTS, P.C.

Paul S. Rabinowitz, M.D. Glen L. Nadel, M.D. Kay Oliver, APRN

ALLERGY IMMUNOTHERAPY AUTHORIZATION

Account Number: _____

Name: _____

I wish to begin a program of allergy immunotherapy, the details of which have been explained to me .

I understand that if another physician has billed this service for me in the past 365 days under my current insurance plan, benefits from my insurance company may be reduced and part of this expense may become my responsibility.

My signature below indicates my permission for Allergy and Asthma Consultants, P.C. to prepare and bill serum for me.

Signature _____

Date _____

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Suite 325
5555 Peachtree-Dunwoody Road
Atlanta, Georgia 30342-1712
(404) 255-9286
Fax: (404) 250-0740

Suite 250
3275 Market Place Blvd.
Cumming, Georgia 30041
(770) 889-8636
Fax: (770) 844-7565

Building 600, Suite 620
11660 Alpharetta Highway
Roswell, Georgia 30076
(770) 740-9600
Fax: (770) 740-9306

Building A, Suite A
3400 McClure Bridge Rd.
Duluth, Georgia 30096
(770) 813-0254
Fax: (770) 813-0255