Chacko Allergy

678-668-4688

nurse@chackoallergy.com

Oral Immunotherapy (OIT) Patient Information
Hybrid- Level II

Welcome

Thank you for choosing Chacko Allergy, Asthma, and Sinus Center for your Oral Immunotherapy (OIT) treatment journey. Our clinical team is dedicated to providing you with safe, customized care and support at every step of your therapy.

Administrative Fee Policy

To enroll in our Oral Immunotherapy (OIT) Program, a one-time administrative fee of **$2,500** is required for each targeted food allergen. This is not covered by insurance. Our clinic treats one food allergen at a time. Please note that this administrative fee must be paid in full before you can schedule your initial Day 1 appointment.

The administrative fee covers:

- Provider review of your medical history and allergy testing.
- Development of your personalized treatment plan.
- Preparation of customized clinical protocols.
- Administrative paperwork.
- Patient education materials.
- Direct procurement and preparation of treatment materials (excluding real food products).
- Clinical coordination, scheduling, onboarding, and communication.

Please note that any real food products needed for your therapy are not covered by the administrative fee and remain the responsibility of the patient.

Insurance and Billing

The **$2,500 administrative fee** is a direct out-of-pocket patient responsibility and will not be submitted to insurance. Standard office visits and other medically necessary clinical services will be billed to your health insurance according to your plan's specific benefits.

Cancellation and Rescheduling Policy

We require a minimum of 72 hours' notice to cancel or reschedule your Day 1 appointment. Late cancellations or missed appointments (no-shows) may result in a $150 cancellation fee.

Preparing for Your First Appointment

- Complete and submit all required administrative forms.
- Pay the administrative fee in full before scheduling.
- Verify and confirm your active health insurance details.
- Ensure the patient is well before the Day 1 appointment. If you are unsure, contact us via email.
- The Day 1 clinical appointments last approximately 4 hours.
- Have the patient eat a meal prior to arriving at the clinic.
- Bring patient-friendly snacks, plenty of beverages, and entertainment with you.

Communicating with Our Office

Email is our preferred method of contact during standard business hours. Please allow up to 24 hours for our team to respond to your message. Email nurse@chackoallergy.com with questions or concerns.

For all immediate medical emergencies outside of our business hours, please call 911 immediately.

If you experience a severe allergic reaction, execute the following emergency protocols immediately:

1. Administer your epinephrine auto-injector without delay.
2. Call 911.
3. Notify our office as soon as possible after emergency services have been contacted or administered.

Office Contact Information

Phone: (678) 668-4688
Fax: (888) 823-1934
Email: nurse@chackoallergy.com

Patient Acknowledgement

I acknowledge that I have received and reviewed the **Oral Immunotherapy (OIT) Patient Information** and that I fully understand and agree to the guidelines, policies, and procedures outlined above.

Patient Name: _____

Patient/Guardian Signature: _____

Provider Signature: _____

Staff/Provider Signature: _____

Date: _____

Delivery Consent Form

Consent to Deliver Patient-Specific Prescription Drugs to Licensed Medical Practitioner

In accordance with GA Rule 480-16-.02(3), which reads *"In order for a patient to authorize a licensed medical practicitioner to hold, administer, or deliver the patient's prescription drug at his or her office location, and the drug was previously dispensed and delivered to the practitioner's office by a pharmacy, the patient must first provide the pharmacy with written authority to conduct a delivery".*

I hereby consent to allowing Ball Ground Pharmacy to deliver my prescription drugs to my licensed medical practitioner. This consent will apply to all prescriptions dispensed by Ball Ground Pharmacy for me, indefinitely, unless revoked in writing at 470 Valley St, Ste 100, Ball Ground Ga 30107.

Patient name _____ DOB:_____

Patient/Guardiansignature:_____ Date:_____

Relationship to patient: _____