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Allergy & Clinical Immunology

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EXTRACT RE-ORDER FORM

Patient Name: _____ _____ Account #: _____

What Vial # are you ordering? _____
Have you had any reactions to your last vial? Yes / No (Please Circle One)
***If you circled "Yes" then please describe below: _____
_____
_____

Amount Due must be paid before extract is picked up for the office. Thank You.

Amount Due is an approximate amount based on Insurance Benefits we have in our system at the time the extract was ordered. Please provide any new insurance information if necessary. Any discrepancies in Insurance payments must be directed to your insurance company.

Order Information: ***PLEASE CHECK THE BOX FOR EACH ITEM THAT YOU ARE ORDERING. EXTRACT OR SYRINGES WILL NOT BE MAILED UNLESS INDICATED.

( ) Extract (patient amt.) :_____
( ) Syringes + : $5.00
( ) Adrenalin + :_____
( ) Mailing Fee + : $4.00 ($8.00 if syringes mailed w/extract)
TOTAL AMOUNT DUE :_____

Please mail, fax, or bring this form with your payment to the office two (2) injections prior to the end of your Allergy Serum. Please allow at least 7-10 days from mailing date to pick-up your new vial of Allergy Extract. Thank You.

Payment Options
( ) Check Enclosed Amount Paid $_____
( ) Credit Card
Charge My: ( ) Visa ( ) Master Card ( ) American Express
Visa/Mc 3 digit printed code on back of card #_____
Amex 4 digit printed code on back of card #_____

Card #_____ Expiration Date:_____

Signature:_____ Phone:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Additional Information:
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