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VIAL TRANSFER RELEASE

Patient Name _____ DOB _____ MRN _____

_____ (initials) I understand that I am responsible for either personally transporting my extracts and related paperwork or paying a fee to Gateway Asthma & Allergy of between ***$15 and $50*** for UPS to deliver each package, to the provider that will be administering my allergy injections in place of Gateway Asthma and Allergy. The total cost is dependent upon how many vials and the value of each vial. This cost cannot be billed to the insurance company and is to be paid in full, by the patient/parent *prior to mailing my extracts*.

_____ (initials) I understand that the vials should be kept refrigerated at an optimal temperature between 35 F and 45 F degrees. This is to ensure full efficacy (effectiveness) of the serum. Exposure to extreme temperatures can decrease the efficacy of serum. Frozen vials MUST be replaced. Vials in extreme high temperatures for longer than 2 days must be replaced. Vials shipped by UPS *are NOT guaranteed* to be free from exposures to extreme temperatures.

_____ (initials) I understand that should the vials need to be replaced, for any reason including lost, broken, damaged, frozen or extreme heat, that I will be fully responsible for payment prior to replacement and that insurance will not be billed for these replacement vials. If there is an insurance claim with UPS, the patient/parent is responsible for filing this claim. Once the vials leave the office of Gateway Asthma & Allergy, all liability for them resides with the patient/parent.

_____ (initials) This waiver shall remain in effect while I am receiving allergy immunotherapy that is provided by Gateway Asthma and Allergy.

_____ Patient/Parent Signature Date _____

_____ Printed Name

_____ Witness Signature