William Johnson MD
Jeremy Katcher MD

12818 Tesson Ferry Rd Ste 205
St. Louis, MO 63128
Phone: 314-421-0663
Fax: 314-722-4688

VIAL TRANSFER RELEASE Date ________________________

Patient Name _______________________________ DOB ____________________ MRN ________________

I understand that I am responsible for either transporting my extracts and related paperwork or providing a prepaid mailing box to deliver these to the physician that will be administering my allergy injections in place of Gateway Asthma and Allergy. _________(initials)

I understand that the vials should be kept refrigerated at an optimal temperature between 35 and 45 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. _________(initials)

I understand that should the vials need to be replaced, for any reason including lost or broken or damaged, that I will be fully responsible for payment prior to replacement and that insurance will not be billed for these replacement vials. __________(initials)

This waiver shall remain in effect until written notice is received by Gateway Asthma & Allergy requesting the Vial Transfer Release be rescinded. __________(initials)

_______________________________________Patient Signature Date ________________________

_______________________________________Witness Signature Date ________________________