ALLERGY AND ASTHMA CENTER OF HILTON HEAD

Thomas C. Beller, MD

60 Main Street, Suite D

Hilton Head Island, SC 29926

Phone: 843-689-6442 Fax: 888-397-1787

Email: **refills@hiltonheadallergy.com**

EXTRACT REORDER FORM

To request a refill of your allergy extract, **complete the following information** and mail/fax it to the office not less than 2 weeks in advance of the date the extract will be required. If needed sooner, you will be charged a **$20.00 Expedited Fee.** For your safety, telephone orders will not be accepted. **ALL FEES MUST BE PAID PRIOR TO YOUR ORDER BEING PROCESSED.**

Patient's Full (Legal) Name: ____

Account Number: ____________________ Phone Number: ____________________

I will PICK-UP extract in: HH ____ Bft ____ NR ____ Please MAIL/SEND extract ______

****WE **SHIP UPS** 2nd Day to **OUT OF STATE ADDRESSES.**. Please include a **$45.00** shipping and handling fee with your order

We **SHIP USPS** to areas **within 75 miles of the HH office at YOUR RISK, we will not be responsible** for the extract once it has been taken to the USPS. Please include a **$25.00** shipping and handling fee with your order ****

Mail To: Name: ____

Address: ____

City, State, Zip: ____

Credit Card #: ____________________________________ CRV: ______ Exp. Date: ___________

PRINT NAME as it appears on the card: ____

I authorize the refill of my (child's) allergy extract. I understand and agree to pay for the refill/s when billed by the Allergy & Asthma Center of Hilton Head.

____ ____________________

Signature (Patient/Parent) (Date)

SHOT RECORDS MUST ACCOMPANY THIS FORM!!!

THIS REQUEST WILL NOT BE PROCESSED WITHOUT current injection schedules.

Expiration Date of EpiPen: ________________________

Current medications: ____

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TCB/ljsn 6/24