Southern California
Food Allergy Institute

SLIT Department

Please email the completed form to SLIT@TPIRC.org

SLIT Billing Schedule Change Request Form

Patient's Name & DOB: _____
_____/_____/_____

(If Sibling) Patient's Name & DOB: _____ _____/_____/_____

Please indicate one of the following:

- ❑ **I would like to skip one SLIT billing cycle. Process my next refill on: ___/___/___**
- ❑ **I would like to place my SLIT account on hold.**
- ❑ **I would like to deactivate my SLIT billing.**
- ❑ **I would like my next refill processed on: ___/___/___**
- ❑ **I would like remove my HOLD and resume automatic SLIT refills on: ___/___/____**

Reason:

_____

_____

_____

Disclaimer

By signing this form I have read and understood the education provided outlining the risks of modifying or pausing my billing cycle and that it may affect my child(ren)'s TIP treatment by not

passing a food challenge successfully and extending my TIP fee. I understand that the Southern California Food Allergy Institute will not be held liable for an unpassed food challenge or extension of TIP fee. I understand that it is my responsibility to contact SLIT to reactivate my account if placed on hold. I understand a patient case will be created and a physician will follow up during a future appointment. SLIT will not refund any outstanding or unused bottles.

_____	_____	_____/_____/_____
Guardian's Full Name	Signature	Date