PARK CITIES
ALLERGY & ASTHMA

NEW PATIENT INFORMATION

Patient Name: _____
Last Name First Name MI

Address: _____
Street Apartment Number

_____
City State Zip

E-mail Address: _____

Home Phone:_____ Work Phone: _____

Cell Phone: _____ Fax: _____

Birth Date: _____ Sex (circle one) : Female Male

Social Security Number: _____

How did you hear about our office? _____

Guarantor: _____
Last Name First Name

Birth Date:_____ Relationship to Patient: Self Parent Guardian

Address (circle one): Same as above See address I've written on the back of page

Employer: _____Work phone: _____

Primary Insurance Company: _____ Policy/ID/Member

Policy/ID/Member Number: _____

Group Number: _____

PARK CITIES
ALLERGY & ASTHMA

Phone Number: _____

Secondary Insurance Company: _____

Policy/ID/ Member Number: _____

Group Number: _____

Phone Number: _____

Emergency Contact: _____

Relationship to patient: _____Home Phone: _____

Work Phone: _____Cell Phone: _____

PARK CITIES
ALLERGY & ASTHMA

Patient Name: _____

Pharmacy Phone Number: _____

Please list all medications you are currently taking, including prescription name, strength and dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you need additional space, please list medications on back of this sheet.

4119 Lomo Alto Drive, Highland Park, TX 75219 | **P** 214.559.0202 | **F** 214.559.0221 | www.pcaaa.com

PARK CITIES
ALLERGY & ASTHMA

FINANCIAL POLICY

Thank you for choosing Park Cities Allergy & Asthma for your care. As a new patient, we thought you would have questions about our financial policy and have provided the information below. **Please initial that you have read and understand the policy.**

1. Payment is due at the time services are rendered. It is important for you to understand that your charges, co-pays, deductibles and services not covered by your insurance company, are your responsibility. We accept Cash, Personal Checks, Visa and MasterCard. There will be a fee for checks returned unpaid.
   Initial: _____

2. We have contracts with most of the major insurance carriers and will file claims as a courtesy to you.
   Initial: _____

3. If your insurance changes during the course of treatment, you must notify us immediately. If you do not notify us and charges incurred are not covered byyour new plan, you will be responsible for payment.
   Initial: _____

4. HMO patients can not be seen without a referral from your Primary Care Physician. You will need to obtain a referral prior to your visit. If a referral is not received at our office prior to your arrival, your appointment will need to be rescheduled.
   Initial: _____

5. Medicare patients are responsible for your deductible (if it hasn't been met) and coinsurance at the time of service. Your secondary insurance does not cover deductibles and coinsurance.
   Initial: _____

6. If you don't have insurance, payment in full is due at the time of your visit unless other arrangements have been made prior to visit.
   Initial: _____

If you have questions or need further information on our Financial Policy, please ask to speak with our Office Manager.

I have read and understand Park Cities Allergy & Asthma's Financial Policy.
I authorize payment of medical benefits to Park Cities Allergy & Asthma, Vinita Schroeder, M.D. P.A., for services performed.

I agree to pay all charges that are my responsibility.

_____ _____

Signature of Patient or Patient Representative (if patient is a minor) / Guarantor

Date

PARK CITIES
ALLERGY & ASTHMA

OFFICE POLICY

We appreciate you choosing Park Cities Allergy & Asthma to partner in your care.

As a new patient, we thought you would have questions about our office policies and have provided information below. **Please initial that you have read and understand the policy.**

1. Underage patients will not be treated without a parent or designated guardian present. If you need to designate a guardian to bring your child to our office, please request "Treatment of a Minor" form at the front desk.

   Initial: _____

2. Medical records will not be released without a signed and dated release form. Once the form is received, our office staff has a two week period to prepare the records for release. There is a $25 fee charged for this service. Please request a "Medical Records Release" form at the front desk.

   Initial: _____

3. **As a patient of Park Cities Allergy & Asthma, your treatment plan usually entails a follow up appointment with the doctor every three or four months. If you are noncompliant with follow up appointments, we can not authorize medication refills through the pharmacy.**

   Initial: _____

4. For patients using a mail order refill program who would like us to fax your prescription as a courtesy to you, it is your responsibility to print out the required forms and bring them in to the office to be faxed on the day of your appointment.

   Initial: _____

5. **If you lose a prescription or lab order form, there will be a $15 charge to complete the forms a second time.**

   Initial: _____

6. **As this is an allergist office, we ask you to be considerate of other patients by not smoking before you come to the office, not wearing perfumes or using lotions with a strong fragrance. Also, please no eating or drinking in the waiting room.**

   Initial: _____

7. **There will be a $25 charge for missed appointments.**

   Initial: _____

8. When calling our office due to illness, please keep in mind that we are seeing patients at the same time. We will get back to you as soon as we possibly can.

   Initial: _____

If you have questions or need further information on our Financial Policy, please ask to speak with our Office Manager.

I have read and understand Park Cities Allergy & Asthma's Office Policies.

_____ _____

Signature of Patient or Patient Representative (if patient is a minor) / Guarantor

Date

PARK CITIES
ALLERGY & ASTHMA

– NOTICE OF PRIVACY PRACTICE –

(PF-1000)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

TREATMENT

Your health information my be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT

Your health information may be used to seek payment for your health plan from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

HEALTHCARE OPERATIONS

Your health information may be used as necessary to support the day-to-day activities and management of Park Cities Allergy & Asthma. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

LAW ENFORCEMENT

Your health information may be disclosed to law enforcement agencies without your permission to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

APPOINTMENT REMINDERS

Your health information will be used by our staff to call and remind you of appointments.

INFORMATION ABOUT TREATMENTS

Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

INDIVIDUAL RIGHTS

You have certain rights under the Federal Privacy Standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information
- has been disclosed
- the right to receive a printed copy of this notice

PARK CITIES ALLERGY & ASTHMA DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Office Manager.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
c/o Park Cities Allergy & Asthma Clinic 4119 Lomo Alto
Dallas, TX 75219

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practice is:

Dr. Vinita Schroeder
c/o Park Cities Allergy & Asthma
4119 Lomo Alto
Dallas, TX 75219

This notice is effective on or after April 14, 2003

PARK CITIES
ALLERGY & ASTHMA

Please note, if you decline to sign this form, we can not file insurance claims for you

– CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFOMATION –

(PF-2000)

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your protected health information will be used by Park Cities Allergy & Asthma or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES

You should review PF- 1000, "Notice of Privacy Practices" for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request a restriction on the use or disclosure of your protected health information.

Park Cities Allergy & Asthma may or may not agree to restrict the use or disclosure of your protected health information.

If Park Cities Allergy & Asthma agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES

Park Cities Allergy & Asthma reserves the right to modify the privacy practices outlined in the notice.

PATIENT SIGNATURES

I have reviewed this consent form and give my permission to Park Cities Allergy & Asthma to use and disclose my health information in accordance with it.

_____

Name of Patient (Please Print)

_____

Signature of Patient or Patient Representative
(If Patient is a minor)

Date:_____

PARK CITIES
ALLERGY & ASTHMA

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT

By signing this form, I acknowledge that Park Cities Allergy & Asthma has provided me with a copy of PF-1000 Notice of Privacy Practices and that I have read and signed PF-2000 Consent to Use and Disclosure of Protected Health Information.

_____

Name of Patient (Please Print)

_____

Signature of Patient

_____

Signature of Patient Representative (if patient is a minor)

_____

Name of Patient (Please Print)

_____

Relationship of Patient Representative to Patient

Park Cities Allergy & Asthma staff should complete if Acknowledgement of Receipt form is not signed.

Does Patient have a copy of the Privacy Notice?

( ) Yes ( ) No

Please explain why the patient was unable to sign an acknowledgement from.

_____

_____