

PARK CITIES ALLERGY & ASTHMA

Park Cities Allergy & Asthma
Vinita B. Schroeder, MD PA

New Patient Information

Patient Name: _____ Birth Date: _____
Last Name First Name MI

Address: _____
Street Apartment Number

_____ *City State Zip*

Sex (circle one): Female Male E-mail Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Social Security Number: _____

Reason for your visit today? _____

How did you hear about our office? _____

If a physician referred you, may we know who? (If you would like records sent to this doctor.)

Guarantor: _____ Birth Date: _____
Last Name First Name MI

Relationship to Patient: Self Parent Guardian

Address: **Same as above** Address if different from patient listed above:

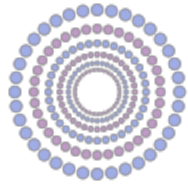
Employer: _____ Work phone: _____

Primary Insurance Company: _____

Policy/ID/Member Number: _____

Group Number: _____ Phone Number: _____

Pharmacy Name: _____



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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.

Drug Allergies:

Emergency Contact: _____

Relationship to patient: _____

Home Phone: _____ **Cell Phone:** _____



Park Cities Allergy & Asthma
Vinita B. Schroeder, MD PA
Office Policies

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 understand each policy.**

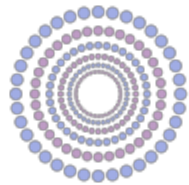
1. Underage patients will not be treated without a parent or designated guardian present. If you need to designate a guardian to bring your child to our office, please request "Treatment of a Minor" form at the front desk. Initial: _____
2. Medical records will not be released without a signed and dated 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.**
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, 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)

Date



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Vinita B. Schroeder, MD PA

Your signature below forms a binding agreement between Vinita Schroeder, MD P.A. (the provider of services) and the Patient who is receiving services, or the Responsible Party (when applicable). Responsible Party is the individual who is financially responsible for payment of bills.

MEDICAL INSURANCE: Our office will offer assistance in maximizing your insurance benefits, however; **PATIENTS ARE RESPONSIBLE FOR CONFIRMING THEIR OWN INSURANCE BENEFITS.** We have contracts with many insurance companies, and we will bill them as a service to you. Please be aware, insurance companies do not guarantee payment. Our office can only **ESTIMATE** the approximate percentage or amount that your insurance may pay. Some or perhaps all of the services may not be considered reasonable and necessary under your insurance plan. In this instance, as the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The Patient or the Responsible Party must:

- Inform Vinita Schroeder, MD P.A. of the current address and phone number for the patient/Responsible Party.
 - Present all current insurance cards prior to each office visit.
 - Contact medical insurance company to confirm coverage.
 - Verify at each visit that the information is current.
 - Pay any required copay or portion insurance will not cover at time of visit.
 - Pay any balance due in full within 30 days of receiving a statement from our office.
- *Partial payments will not be accepted.

PAYMENT ARRANGEMENTS: For your convenience we accept all major credit cards, cash and checks. We do not accept postdated checks. Extended payment plans are available through corporate financing (Care Credit) and we can easily assist you with the application process, which must be completed and approved prior to the actual procedure/office visit.

RETURNED CHECK POLICY: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), or Account Closed (AC), the Patient or Patient's Responsible Party will be responsible for the original check amount in addition to a \$30.00 Service Charge. Once notified by our office, if payment in full is not made within 15 days by the Patient or Responsible Party, the account may be turned over to our collection agency. Patients who allow their account to go to collections will be expected to pay in full for all future services, or may be dismissed from the practice.

COLLECTION FEES AND EXPENSES: You understand and acknowledge that you are responsible for any fees or expenses, including reasonable attorney's fees and collection agency fees incurred by Vinita Schroeder, MD P.A. in collecting any balances due under the terms of this Agreement. Fees will be in addition to the balance due.

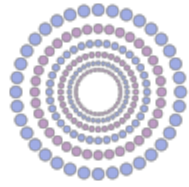
PRE-AUTHORIZATION AND REFERRALS: Many insurance carriers require a referral from your Primary Care Physician (PCP), before you receive care from a specialist; it is your responsibility to obtain a referral or prior authorization if your medical coverage requires it.

****Please note, if you decline to sign this form, we cannot file insurance claims for you****

By signing below, you agree to accept **FULL FINANCIAL RESPONSIBILITY** as a patient who is receiving services or as the parent/guardian for the patient. You authorize payment of benefits to Vinita Schroeder, MD P.A. Your signature verifies that you have read the above, had the opportunity to ask and have answered any questions, understand your responsibilities, and agree to these terms.

Signature of patient: (Parent or Guardian if patient is a minor)

Date



PARK CITIES ALLERGY & ASTHMA

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Vinita B. Schroeder, MD PA

Notice of Privacy Practices

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.

Uses and Disclosures

Treatment

Your health information may 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.

Health Care 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.

***Persons Authorized to be informed of my medical conditions, if any:**

_____ Relation: _____

_____ Relation: _____



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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

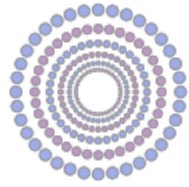
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Office Manager.

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:

Dr. Vinita Schroeder
Park Cities Allergy & Asthma
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.



PARK CITIES ALLERGY & ASTHMA

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Consent to Use and Disclosure of Protected Health Information

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.

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.

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 or Patient Representative
(If Patient is a minor)

Date: _____



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Vinita B. Schroeder, MD PA
Patient's Acknowledgement of Receipt

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.
