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NEW PATIENT INFORMATION

Patient Name: Birth Date:

*Last Name First Name MI*

Address:

*Street City State Zip*

Sex (circle one): Female Male

Email Address:

Home Phone: Cell Phone:

Work Phone:

Social Security Number:

Guarantor: Birth Date:

*Last Name First Name MI*

Primary Insurance: Phone Number:

Policy/Member Number: Group Number:

Relationship to Patient: Self Spouse Dependent Employer:

Emergency contact: Phone Number:

Relationship to patient:

Primary Care Physician: Referred by:

Pharmacy Name: Phone Number:

Pharmacy Address:

What problem let you to seek this evaluation?

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Do you have any allergies to medications, foods, or insects?

Please list all current medications:

**PAST MEDICAL HISTORY:**

Please list medical conditions:

Hospitalizations or surgeries:

Have you seen an allergist in the past? YES NO If yes, who?

Were you allergy tested: YES NO Have you tried allergy shots: YES NO

When do your allergy symptoms occur: Fall Winter Spring Summer Year round

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**FAMILY HISTORY:**

Family history of any serious medical conditions:

Does any of your family members have a history of the following?

Allergies (**A**) Asthma (**AS**) Eczema (**E**) Auto-immune (**AI**)

Please enter one or more of the above letters in the spaces provided

Mother Father Sister Brother

Maternal Grandmother Maternal Grandfather

Paternal Grandmother Paternal Grandfather

**SOCIAL HISTORY:**

Occupation:

Marital status: Married Divorced Separated Single

Children (ages):

Smoking Status: Current Quit Never

If smoking, how may packs a day have you smoked? For how many years:

If you quit, how many years did you smoke? When did you quit:

Alcohol use: Current Former Non-drinker

Recreational drug use: YES NO

Hobbies:

Do you exercise: YES NO

**ENVIRONMENTAL HISTORY:**

Do you live in a: House Apartment Townhome

How old is the residence: Type of Flooring:

Pets: None Cats (#) Dogs (#) Other:

Do pets sleep indoors or outdoors: In your bedroom: YES NO

Do you have dust mite proof encasings: YES NO

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**Have you had any of the following symptoms in the last 2 weeks? Please check all that apply.**

**General**

* Chills
* Fever
* Fatigue
* Weakness
* Sleep disturbance
* Night sweats
* Weight loss
* Weight gain

**Respiratory**

* Cough
* Wheezing
* Shortness of breath
* Chest tightness
* Sputum production
* Exercise intolerance

**Cardiovascular**

* Palpitations
* Increased heart rate
* Irregular pulse
* Chest pain
* Swelling of lower legs

**Neurologic**

* Headaches
* Migraines
* Speech/language

Dysfunction

* Sensory dysfunction
* Developmental delay
* Reduction in cognitive

Function

**Musculoskeletal**

* Joint pain
* Joint swelling
* Muscle Pain/cramp

**Ears, Nose, Throat**

* Nasal congestion
* Itchy nose/throat
* Runny nose
* Sneezing
* Post-nasal drip
* Sinus pressure/pain
* Throat clearing
* Snoring
* Hoarseness
* Difficulty swallowing
* Loss of taste/smell
* Ear pain/pressure
* Ringing in Ears
* Dizziness

**Skin**

* Hives
* Itching
* Rash
* Eczema
* Dry skin
* Swelling
* Sores

**Immunologic**

* Chronic infections
* Recurrent infections
* Recurrent bronchitis
* Recurrent pneumonia
* Recurrent fever
* Fungal infections

**Heme/Lymphatic**

* Swollen lymph nodes
* Tender lymph nodes
* Easy bleeding
* Anemia

**Eyes**

* Itching
* Redness
* Watery
* Discharge
* Swelling around eyes
* Swollen eyelids
* Burning
* Pain
* Blurred vision
* Decreased vision
* Photophobia

**GI**

* Reflux
* Heartburn
* Difficult swallowing
* Painful swallowing
* Food impaction
* Nausea
* Vomiting
* Constipation
* Abdominal pain
* Gas
* Blood in stool

**Psychiatric**

* Anxiety
* Depression
* Panic attacks
* Moodiness
* Stress
* Memory loss
* Problem concentrating
* Agitation

**Endocrine**

* Frequent thirst
* Voice change
* Frequent urination
* Hair changes
* Heat intolerance
* Cold intolerance

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**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 2 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 cannot 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: \_\_\_\_\_\_

1. **If you lose a prescription or lab order form, there will be a $15 charge to complete the forms a second time.**  Initial: \_\_\_\_\_\_
2. **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.**
3. **There will be a $25 charge for missed appointments without 24 hour notification.**

Initial: \_\_\_\_\_\_

1. 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 Date

(if patient is a minor)

Name of Patient

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**Financial Agreement**

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 Park Cities Allergy and Asthma 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**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.

**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:

Relation:

**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.

**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 “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

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

Date