



Peter N. Schochet, MD
Hauw S. Lie, MD

Board Certified Pediatric Pulmonologists



Patient Profile

Child/Patient Name _____ Male Female Date of Birth _____
 Patient resides with: Mother Father Other ___ Parents Marital Status Married Single Divorced/Separated
 Address where Child resides _____ City _____ Zip _____
 Race _____ Ethnicity Hispanic Not Hispanic Preferred Language _____
 Email address _____

Parents/Legal Guardian Information

Mothers Information

Name _____
 Date of Birth _____
 Address _____
 City _____ St _____ Zip _____
 Home Phone _____ Cell _____
 Employer _____
 Work Phone _____

Fathers Information

Name _____
 Date of Birth _____
 Address _____
 City _____ St _____ Zip _____
 Home Phone _____ Cell _____
 Employer _____
 Work Phone _____

Are other adults approved to bring your child to the visit? Yes No Please list their name and inform them to bring ID
 _____ Emergency contact _____ phone _____

Insurance Information

Insured Name _____
 Name of Insurance Company _____ Phone number _____
 Patient ID# _____ Group# _____
 Do you have any other insurance this includes Medicaid? Yes No If so what is the name of the insurance _____
 Referring Physician _____ Pediatrician _____

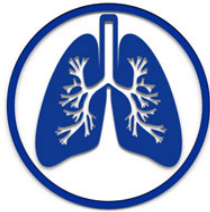
Pharmacy

What is the name of pharmacy and cross street of the local pharmacy you prefer for us to send medications to

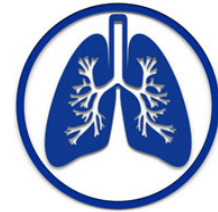
 Do you use a mail order pharmacy? Yes No If so what is the name of the pharmacy? _____
 Do you give our office permission to retrieve patients Rx history from external sources? This is to include but not limit to
 pharmacies, other physicians, hospital, etc. Yes No

Signature _____ Date _____
 Print Name _____

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Financial Responsibility Policy

Financial responsibility is determined first, by the insured, and second by the adult signing the patient in at the time of the appointment. Please note that both, if different, will be submitted to collection agencies should the financial obligations of appointments not be met in a timely manner.

Charges will be accumulated and routinely filed with your insurance company during the course of treatment by Peter N. Schochet, MD. Charges not covered by your insurance, patient co-pays, deductibles, and co-insurance will be your responsibility and are due at the time of service.

If your insurance company requires a referral from your primary care physician, *you* will need to contact your PCP for the referral. Treatment provided by this office without the required referral will serve as your consent for treatments not covered by insurance, and will be payable at the time of service.

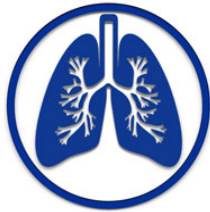
Divorce and Separated Parents

- It is not this office's legal responsibility or desire to arbitrate or enforce legal divorce judgments. Our responsibility is to provide quality child and adolescent health care.
- If in the divorce settlement, only 1 (one) parent is assigned responsibility for the medical expenses of the child, and the "non-assigned" parent presents with the child seeking medical attention, it is the presenting parent's responsibility to provide payment for those medical services as rendered, and then in turn forward the medical statement to the "assigned" parent for reimbursement.
- It is NOT our office's responsibility to collect payment from the absent parent, even though that parent has been assigned responsibility of the child's medical expenses. This is a matter that should be resolved by the parents outside this office.

Notice to Parents of Financial Interest

You are informed by this Notice that Dr. Schochet holds a financial interest in the **Texas Health Center for Diagnostics and Surgery**, which includes the **Pediatric Sleep Institute**. You have the option, at your discretion, to use an alternate health care facility.

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Please check one of the following:

_____ I certify that I have no insurance and will be solely responsible for payment in full.

_____ I certify that the insurance reported to Peter N. Schochet, MD is a complete and current listing. I understand the office will not extend credit on, or submit a claim for any insurance not reported at the time of service.

I understand that any claim not paid by my insurance within 60 days from the date filed may become my responsibility and is payable upon billing.

Authorization to Release Medical Information

I authorize Peter N. Schochet, MD to release any medical information requested by physicians or insurance companies regarding treatment at this facility.

Insurance Assignment

I hereby authorize payment to be made directly to Peter N. Schochet, MD by my insurance company for any charges for services covered by the terms of my policy. I agree to cooperate, aid, and assist the facility in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I have read and understand the above information and hereby authorize Peter N. Schochet, MD to prescribe and provide treatment for my child.

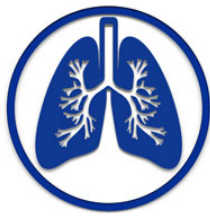
Patient Name (Please print): _____

Parent or guardian name (for minor patient): _____

Parent or guardian signature (for minor patient): _____

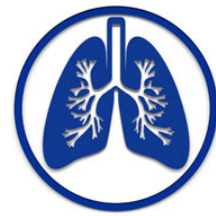
Social Security # of the above: _____ - _____ - _____ Date: _____

See statement above regarding financial responsibility.



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CANCELLATION AND NO SHOW POLICY

We understand that situations may arise which makes it necessary to cancel your appointment. Accordingly, we request that you provide at least **24-hour notice of cancellation**. This will enable the physicians to offer that time slot to other patients who need to be seen. Appointments with our specialists are in high demand, and your early cancellation will give another person access to timely medical care.

Cancellation Fee

Office appointments, which are cancelled with less than a 24-hour notification, may be subject to a **\$25.00 cancellation fee**.

No Show Fee

Patients who do not show up for their appointment and who do not call to cancel or reschedule, will be considered a No Show. No Shows are also subject to a **\$25.00 No Show fee**.

Patients who do not show, No Show, for two or more appointments in a 12-month period may be dismissed from the practice.

The Cancellation and No Show fees are the sole responsibility of the guarantor and cannot be billed to the insurance company.

Please sign that you have read and are aware of the above **Cancellation and No Show Policy**.

PATIENT NAME (Please print): _____

Parent or guardian name (for minor patient): _____

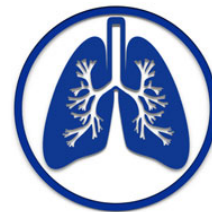
Parent or guardian signature (for minor patient): _____

Date: _____



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Notice of Office Privacy Practice
Acknowledgement Receipt

I _____ acknowledge that I have reviewed a copy of the “Notice of Privacy Practices of Peter Schochet, MD, PA”.

This Notice describes how Peter Schochet, MD, PA may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

In addition, I have been offered a copy of the Notice of Privacy of Peter Schochet, MD, PA.

(Signature of Parent/Guardian)

(Date)

(Name of Patient)

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