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 _____

Pediatric Pulmonologists
Peter N, Schochet, MD & Hauw S. Lie, MD
6130 West Parker Road, Suite 505, Plano, Texas 75093
972-981-3251 • 972-981-3254 FAX • www.pedilung.com

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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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