



ROBERT D. COOK, M.D., P.A.
DIPLOMATE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

4150 NORTH LAMAR • AUSTIN, TX 78756
PH: (512)467-0978 • FX: (512)467-8066
centraltexasallergy.com

Dear New Patient:

Welcome to our practice. We are very pleased that you have selected us for your medical care. Enclosed are forms for you to fill out **in advance** of your appointment to assist our office staff and Dr. Cook in making sure that we have all the information necessary to provide you with quality care and treatment. Please fill out all the forms completely in black ink. If you have any questions or problems filling out the forms, do not hesitate to call so that we may assist you. **When you have completed your forms, please return them to our office prior to your appointment.** This will allow Dr. Cook to review your medical history prior to your appointment and will allow our staff to have your chart prepared in advance in order to help prevent delays in seeing the doctor.

If you have been treated by a physician or hospital for the reason you are visiting us (example: allergies, asthma, hives, anaphylaxis), then you may want to request copies of pertinent medical records in advance of your appointment. You may either have them give the records to you directly, or they can mail them to us.

If you belong to an HMO such as HealthSelect, HMO Blue, One Health Plan HMO, and others, **it is your responsibility to make sure that you have a valid referral from your primary care physician's office.** IF you do not have a valid referral, you will be required to pay for your office visit at our standard rate at the time of your office visit.

Dr. Cook tries very hard to stay on time with his patients, but sometimes medical emergencies do occur which can cause him to run behind. You can do your part by showing up on time for your appointment with all the paper work completed and sent back to us prior to your appointment. **Since the enclosed forms take quite a long time to fill out, we may have to reschedule your appointment if they are not completed by the time your appointment is scheduled to begin.**

We will call you the day before your appointment to confirm your visit. Unfortunately, we have been experiencing a large number of patients who are missing their appointments or canceling at the last minute. This is extremely unfair to those patients that are waiting to be seen. **Therefore, if we do not receive a cancellation notice from you within 24 hours of your appointment, we will assess a \$50 fee. Skin test appointments cancelled less than 72 hours of the appointment time will be charged a \$125 fee.** To prevent receiving this bill, please call us at 467-0978 to cancel or reschedule your appointment.

Once again, welcome to our practice. We look forward to providing you with quality care.

Cordially,
Cheryl Cook
Administrator



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PATIENT FINANCIAL POLICY AGREEMENT

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept [Visa, Mastercard and Discover].

YOUR INSURANCE

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

REFERRALS

If your insurance company requires a referral to see a specialist, and you arrive for your appointment without a referral, you will be responsible for the complete charge of the visit at the time of service. If we receive a valid referral after your visit you will be reimbursed your portion. You must provide a copy of your insurance card at the time of your visit. If we are not able to verify your insurance coverage, you will be responsible for full payment at the time of service.



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TODAY'S DATE:		PATIENT INFORMATION			
FIRST NAME		MI	LAST NAME		DOB
ADDRESS			CITY	STATE	ZIP
HOME PHONE	WORK PHONE	OTHER / BEEPER / MOBILE		E-MAIL	
SS#	DL#	SEX: M() F()	AGE	MARITAL STATUS S() M() W() SEP() D()	
PATIENT'S EMPLOYER		WORK FULL TIME? Y() N()		FULL TIME STUDENT? Y() N()	
BUSINESS ADDRESS				OCCUPATION	

REFERRED BY		ADDRESS (IF MD)	
PRIMARY CARE PHYSICIAN		ADDRESS	
IN CASE OF EMERGENCY, NOTIFY		WORK/CELL PHONE	RELATIONSHIP TO PT
SPOUSE'S NAME	DOB	WORK/CELL PHONE	EMPLOYER

PRIMARY INSURANCE COMPANY NAME		
NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	POLICY HOLDER SS #
CERTIFICATE OR POLICY #	GROUP #	POLICY HOLDER DOB
SECONDARY INSURANCE COMPANY NAME (Circle NONE IF NOT APPLICABLE)		
NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	POLICY HOLDER SS #
CERTIFICATE OR POLICY #	GROUP #	POLICY HOLDER DOB

IF PATIENT IS A MINOR OR A FULL TIME COLLEGE STUDENT:

MOTHER'S NAME		DOB	SS #
HOME ADDRESS		CELL PHONE	HOME PHONE
OCCUPATION	EMPLOYER		WORK PHONE
FATHER'S NAME		DOB	SS #
HOME ADDRESS		CELL PHONE	HOME PHONE
OCCUPATION	EMPLOYER		WORK PHONE

RESPONSIBLE PARTY FOR PAYMENT (please circle)
 SELF, MOTHER, FATHER, OTHER (If Other, list Name, Relationship to Patient, Phone & Address)

In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

G:\FrontOfficeMasters\NewPatientForms\ptinfo.doc\120709

SIGN: _____ **DATE:** _____



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Name: _____

Date of Birth: _____

MEDICATIONS

Please list **ALL** current medications

Strength and when taken

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

PLEASE LIST ALL FOOD AND MEDICATION ALLERGIES:

Food or Medication	Reaction (hives, swelling, anaphylaxis, etc)	Approx age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you tried the following medications

Were they effective?

- | | | |
|-------------|----------|----------|
| 1. Claritin | Yes / No | Yes / No |
| 2. Allegra | Yes / No | Yes / No |
| 3. Zyrtec | Yes / No | Yes / No |
| 4. Flonase | Yes / No | Yes / No |
| 5. Nasonex | Yes / No | Yes / No |
| 6. Nasacort | Yes / No | Yes / No |

SURGERIES/HOSPITALIZATIONS

Surgery/hospitalization	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____



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HIPPA ACKNOWLEDGMENT

Please initial the following:

_____ I acknowledge that **Robert Cook, M.D., P.A.** has provided me with a written copy of the Notice of Privacy Practices and that I have been afforded the opportunity to read the Notice of Privacy and ask questions.

FINANCIAL POLICY AGREEMENT

_____ For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

_____ I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

MEDICAL RECORD RELEASE

_____ I authorize the release of any medical or other information necessary to process medical claims made to my health insurance plan. I also authorize payment of benefits by my health insurance company, to Dr. Robert Cook or to Central Texas Allergy & Asthma Center.

PATIENT CONTACT INFORMATION

1. Please list the family members or other persons whom we may inform about general medical conditions or your diagnosis:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

2. Please list phone numbers where we may leave confidential messages

_____ NONE _____ HOME _____ WORK/CELL

E-PRESCRIBE AUTHORIZATION

As of September 1, 2010 Dr. Cook's office began using E-Prescribe. I have been informed of E-Prescribe. _____ (patient initials). I grant / do not grant permission that my full prescription history may be downloaded for review by Robert D. Cook, MD and his staff.

Signature patient guardian _____

Date _____

Printed Name _____

PATIENT/AUTHORIZED PERSON'S SIGNATURE

Signature patient guardian _____

Printed Name _____

Date _____