DAVID L. SCHNEIDER, M.D., A.P.M.C

3225 Danny Park Suite 100 Metairie, LA 70002 * 504-889-0550* 504-889-0582 (fax)

15825 Professional Plaza, Suite A Hammond, LA 70403 * 985-429-1080* 985-429-1092 (fax)

New Patient Information: **Today's Date:**_________________

Patient Name____Date of Birth________________
Last First Middle Initial

Address__________________________Apt #_____City__________________State________Zip+4 code______

Home Phone (____)____________________________ Cell # (____)________________________________

Sex_____Race______ Marital Status_______ Social Security #__________________Driver's License #___________

Email address ____

Any known drug allergies YES or NO. If yes please list____

Employer_________________________________Occupation_________________Work # (___)____________

Employer's address____

Name of Primary Care Physician____________________________Phone # (_____)_________________________

Pharmacy, Phone & Address____

Payment and Policy Holder's Information:

Name of Person Responsible for Payment____
Last First Middle Initial

Address___________________________Apt #____________City______________State_____Zip_____________

Home Phone (____)___________________ Cell # (____)_______________Sex________Race__________

Date of Birth__________Marital Status_____Social Security #__________________Driver's License #____________

Employer ________________________________Occupation__________________Work # (__)______________

Employer's address____

Email address (optional)____

Name of Parent Other Than Policy Holder____
Name Day Time Phone #

Emergency Contact ____
Name Relation Phone #

To help us thank the person whom referred you to us, please indicate how you heard about our practice? Please circle person or source of your referral and indicate the name of the referral.

Friend or Family________________________________Doctor________________________________

Insurance Plan Yellow Pages Media (TV/Radio/Newspaper) Drive By SpeeClinical Research Internet Other Source (please indicate source)___________________________

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OFFICE POLICIES

PAYMENT POLICIES:

Full payment is due at time of service. We accept cash, checks, and Visa/MasterCard/Discover/American Express. Commercial Insurance Carriers may or may not pay for office services. Please be advised that it is the patient's responsibility to obtain referrals from their Primary care Physician. If a patient is seen without a referral, the Patient, Parent or Guardian will be held responsible for payment for any services that are rendered.

Co-Payments are due at time of service.

If balance is not paid in a timely manner then we will terminate the availability of our services to you within 15 days.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Dr. David Schneider to administer in his office such procedures and treatments considered therapeutically necessary after full discussion and furthermore understand that payment is due in full at time of service except where prior pre-certified arrangement has been made with the insurance carrier; in such case, I authorize payment of medical benefits to Dr. David Schneider.

HOW WILL YOU BE PAYING FOR YOUR VISIT?

Please Circle Cash Check Credit Card Debit Card

I HAVE READ THE PAYMENT POLICY AND INSURANCE AUTHORIZATION POLICY. I UNDERSTAND AND AGREE TO THIS POLICY AND ASSIGN ANY AND ALL BENEFITS PAYABLE UNDER INSURANCE POLICY(S) TO DAVID L. SCHNEIDER MD APMC

____

Signature of Responsible Party Today's Date

David L. Schneider MD, APMC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, **[name of patient]** ____________________________, acknowledge and agree that I have received a copy of **David L. Schneider MD, APMC**'s Notice of Privacy Practices.

____	__________________________
Patient Signature	Date
____	__________________________
Patient Legal Representative (if applicable)	Date
____	__________________________
Print Name of Legal Representative	Relationship to patient

FOR CLINIC USE ONLY:

David L. Schneider MD, APMC made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

> **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**

David L. Schneider, M.D.
A Professional Medical Corporation
Sweta Shah M.D.

Fellow of the
American College of
Allergy, Asthma & Immunology

Fellow of the
American Academy of
Allergy, Asthma & Immunology

Board Certified
American Board of
Allergy & Immunology

July 25, 2005

Dear Patients:

For all new patients let me extend a warm welcome to the practice. For established patients, let me thank you in putting your trust in me for your medical concerns for both you and your family.

I have seen my practice in Metairie grow with leaps and bounds in the decade I have been here and am proud to have made significant investments in facilities and personnel to best serve our patients.

Unfortunately, we have been saddled with numerous instances of patients not showing for scheduled exams, many times with no prior notice given DESPITE our office contacting the patients 24 hours before.

We do not run a volume based practice where we see 40 patients or more a day. Allergy work-ups are time consuming and labor intensive so that we cannot double book and still provide the service that you have come to expect and we hope to provide. By not attending an appointment, we are forced to schedule sick patients further and further away as we hold the spot for scheduled patients.

So we have the following policy in effect: there is a no show fee of $35 if no prior notice is given to our office about your missed appointments (24 notice please). If there are three instances in a calendar year of no shows, we will respectfully request you seek an alternate provider for your medical care.

Thanks for your attention.

Sincerely,

David L Schneider, MD

READ and ACCEPTED ____