Erin L. Koster, M.D. P.A.

Welcome to our practice!

On behalf of our staff, we welcome you to our office. We are pleased that you have selected us to care for your healthcare needs and we look forward to your initial visit. We are located on the ***Texas Health Presbyterian Campus in Medical Office Building 1***, Tower A elevators to the right inside the front entrance to the hospital. There is parking available directly across from the entrance to the hospital and adjacent parking around the campus that includes the parking garage. ***Valet parking*** is also available for an additional cost of $4.00 in the front of the hospital or FREE valet in front of **building 2**. Parking is unpredictable so please take that into consideration when preparing to arrive for your appointment. You can click on the map to better understand the campus layout.
https://www.texashealth.org/plano/Documents/System/Maps/THP_Campus_Map.pdf

We want you to know that we are committed to provide you with the highest quality of maternal fetal care in the most gentle, efficient, and enthusiastic manner possible. We pride ourselves on making your visit a pleasant experience for you, while providing you with the best treatment.

Dr. Koster's primary concern for patients is that they are comfortable and reassured during their visit, while becoming adequately informed about the high risk nature of their pregnancies. She specializes in women over 35, multiple gestation pregnancies, and with other health concerns such as diabetes, hypertension, and autoimmune disorders. She provides pre-conceptual counseling for high-risk couples seeking pregnancy.

During your first visit, a comprehensive examination will be completed by Dr. Koster personally. This exam will include necessary ultrasound and blood work allowing her to diagnose your condition and discuss it with you. The appointment will take approximately 30 minutes, depending on the complexity of your visit.

We appreciate the value of your time, and except for emergency situations, you can expect us to be on time for you. We will appreciate the same courtesy. If you have insurance, please bring your insurance card and identification with you. If a card is not available please have all insurance and pertinent information to submit your services to your insurance plan for reimbursement.

Should you have any questions about our practice, services, or policies please do not hesitate to contact our office or visit our website at www.erinkostermd.com. Our new patient registration forms are electronic and will be emailed to you for completion prior to your appointment. If you don't have access to the internet or a printer, please arrive 15 minutes before your scheduled appointment to complete registration forms. We look forward to meeting you at your visit.

Sincerely,
Erin L. Koster MD, PA
6130 W. Parker Road
Suite 512 Medical Office Building 1
Plano, Texas 75093
972-981-8870

ERIN L. KOSTER M.D., PA Today's Date _____

NEW PATIENT INFORMATION

PATIENT INFORMATION
Name: _____Date of Birth: _____
Address: _____
City, State, Zip: _____Social Security #:_____
Marital Status:_____Email Address: _____
Cell#: _____Work#: _____Home#: _____
Referring Provider: _____Estimated due date:_____
PATIENT EMPLOYMENT [ ] Employed [ ] Homemaker [ ] Student
Employer: _____Phone: _____

EMERGENCY CONTACTS
Name: _____Relation:_____Phone#: _____
Name: _____Relation:_____Phone#: _____

GUARANTOR (person responsible for bill) [ ] Same as Patient [ ] Other relation_____
Name: _____Social Security #: _____
Date of Birth: _____Employer:_____Phone#_____
Address:_____City, State, Zip: _____

PRIMARY INSURANCE [ ] Same as Patient [ ] Spouse [ ] Parent
Insured's Name: _____Insured's Social Security#: _____
Insured's Date of Birth: _____Insurance Plan Name: _____
Insured's ID: _____Policy Group: _____

SECONDARY INSURANCE [if applicable] [ ] Same as Patient [ ] Spouse [ ] Parent Insured's
Name: _____Insured's Social Security#: _____
Insured's Date of Birth: _____Insurance Plan Name: _____
Insured's ID: _____Policy Group: _____

AUTHORIZATION OF BENEFITS AND FINANCIAL RESPONSIBILITY
I hereby authorize any and all insurance benefits to be paid directly to the physician. I acknowledge that I have read the office policies and understand that I am financially responsible for any unpaid balance.I authorize treatment by Dr. Erin Koster and staff.

AUTHORIZATION OF INFORMATION RELEASE AND PRIVACY POLICY
I authorize the physician to release any information required by my insurance company. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices. I have also read and understand the privacy policies and understand that the authorization is effective unless and until revoked by the patient or the patient's personal representative and can be revoked or terminated by submitting a written revocation to the practice.

AUTHORIZATION FOR ELECTRONIC COMMUNICATION
I am authorizing that my statements and any other correspondence transmitted to me from the office of Erin L Koster, MD PA may be sent to my e-mail address.

_____Date_____
Name of Patient (Print)

_____Date_____
Signature of Patient

_____Date_____
Patient Representative- **Required if patient is a minor**

ERIN L. KOSTER MD. PA Today's Date _____

NEW PATIENT HISTORY

Name _____ Date of Birth _____
Reason/Indication/Chief Complaint: _____
Referred by: _____Last menstrual period:_____EDD:(est. due date)_____

REVIEW OF SYSTEMS (please select all that apply in last12 months)

CONSTITUTIONAL ___NONE ___Fever___Chills___Feeling poorly___Tired___Weight Loss ___Weight gain
EYES ___NONE___Eye Pain ___Wears Glasses___Spots before eyes ___Vision changes ___Dry Eyes
EAR/NOSE/THROAT ___NONE___Earaches ___Seasonal allergies ___Nose Bleeds___Sinus issues ___Sore throat
CARDIOVASCULAR ___NONE ___Chest pain ___Palpitations ___Leg Pain ___Tachycardia
RESPIRATORY ___NONE ___Shortness of breath ___Wheezing ___Cough ___Short of Breath
GASTROINTESTINAL ___NONE___ Abdominal pain ___Vomiting ___Nausea ___Constipation ___Diarrhea
OB/GYN GU ___NONE ___Frequency___Dysuria ___Blood in urine ___Cloudy urine ___ Stress incontinence
OB/GYN ___NONE ___Abnormal bleeding ___Irregular/painful menses___Pelvic Pain ___Vaginal Discharge
MUSCULOSKELETAL ___NONE ___Arthralgia (joint pain) ___Limb pain/swelling ___Joint swelling/stiffness
INTEGUMENTARY (SKIN) ___NONE ___Acne ___Breast discharge ___Itching ___Breast pain ___Dry skin
NEUROLOGICAL ___NONE ___Confused ___Memory problems ___Dizziness ___Headaches/Migraines
PSYCHIATRIC ___NONE ___Suicidal ___Sleep disturbances ___Anxiety ___Depression
ENDOCRINE ___NONE ___Hair loss ___Hot flashes ___ Heat/cold intolerance ___Muscle Weakness
HEMATOLOGY/IMMUNOLOGY ___NONE ___ Easy bleeding ___ swollen glands
OTHER (not listed above)_____

PATIENT SOCIAL AND MEDICATION HISTORY

Occupation:_____Marital Status:_____ Height:_____ Weight: _____
Children:_____ Pets:_____ Special Diet: Yes/ No Specify:_____
Exercise: Yes/ No Tobacco Use: Yes/ No Prior Smoker:Yes/No Year last smoked:_____
Alcohol Use:Yes/ No #/frequency:_____ Illicit Drugs: Yes/ No Frequency/Type: _____
Medications-check all that apply: ___None ___Labetalol __Procardia ___Terbutaline ___Synthroid
___PTU ___ASA ___Heparin/Lovenox ___Prenatal Vitamins Other:_____
Drug Allergies: NKDA/ Other:_____Allergies: (other)_____

PATIENT MEDICAL HISTORY (select all that apply)

Arthritis	Seizures/epilepsy	Stroke
Asthma	Liver disease	Chronic Pelvic Pain
Chronic lung disease/Cancer	Skin Disease	Endometriosis
Diabetes	Psychiatric disorder	Stomach/Intestinal Disease
Thyroid disease	Heart disease	Kidney disease
Eye disease	Hypertension	Other:_____

PATIENT SURGICAL HISTORY (select/list any surgeries and approximate date)

Cesarean Section _____ Myomectomy _____ Laparoscopy _____
Gallbladder _____ Ovarian Cyst _____Kidney_____
Appendectomy _____ D & C _____ Cone/LEEP _____
Tonsillectomy_____ Intestinal _____ Other:_____

FAMILY HISTORY (please list relation)

Diabetes _____Hypertension _____Thyroid disease _____
Osteoporosis_____Cancer: Breast_____ Ovarian_____
Prostate:_____ Colon_____Brain:_____

Psychiatric illness _____ Other_____

OB HISTORY / PAST AND PRESENT PREGNANCY RELATED RISK FACTORS

Pregnancies#____ Live births#:____ Abortions#(spontaneous or elective):_____ Miscarriages#:_____
Living children#:____ PreTerm Births#:____ Pregnancy loss <12weeks #____ Pregnancy loss12-24weeks# ___
Late fetal death>24weeks#____ Pregnancy loss other:_____

PREGNANCY COMPLICATIONS ___NONE ___Diabetes___High Blood Pressure ___Cerclage ___Bleeding
___Abruption ___Incompetent Cervix ___IUGR(growth failure) ___Pre-eclampsia ___ PROM ___Fetal Abnormalities

BIRTH YEAR	TYPE OF DELIVERY	WEEKS GESTATION	BIRTH WEIGHT	GENDER

Erin L. Koster MD, PA Today's Date _____

Standard Authorization of Use and Disclosure of Protected Health Information

The information covered by this authorization should include:

____ALL information in my file (includes demographics, reports, labs, and any other information obtained) or

____LIMITED disclosure only:_____

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA we are not allowed to give this information out without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

The information described above may be disclosed to:

_____
Name of person/organization Relationship to patient

_____
Name of person/organization Relationship to patient

_____
Name of person/organization Relationship to patient

This authorization is effective unless and until revoked by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Office Manager to terminate this authorization. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Patient:

-You may inspect or copy information used or disclosed under this authorization

-You may refuse to sign this authorization

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

I understand that the information listed above will be disclosed by Erin L. Koster, M.D. P.A. for education, discussion of treatment plan, and/or medical decision making. By signing this document I am authorizing Erin L. Koster, M.D. P.A. to release my information to the organization(s)/person(s) listed above.

_____
Name of Patient (Print) Date

_____
Signature of Patient Date

_____
Signature of Patient Representative (if minor) Relationship to Patient Date

Erin L. Koster MD, PA **OFFICE POLICIES** **updated 7/25/17**

Thank you for choosing our office for your medical care. We strive to provide you with excellent, compassionate service while under our care. In order to provide this high level of service and better your healthcare experience, we have some office policies that we would like to share with you. After reading, please sign the page at the bottom to show that you have read and understand these policies. By signing, you agree to our policies and acknowledge charges that will be assessed in case of violated policies as described below.

APPOINTMENT TIMES: Appointment times are scheduled for your convenience. We expect our patients to be in the office ready to be seen at their appointment time. If paperwork needs to be updated or insurance cards copied, that must be taken care of prior to the appointment time. Dr. Koster strives to run on time but on occasion an emergency will arise that will cause her to get behind. In that case, we will let you know as soon as possible and give you the option to wait or reschedule your appointment. We understand that your time is valuable too. All efforts are made to run on time, and we expect our patients to arrive in plenty of time for their appointments. If you miss an appointment without canceling, you have denied another patient the chance to be seen during the time period. In this case you will be subject to a $15.00 cancellation charge for reserving the doctor's time. If you are late for your appointment, you will become a "work-in" status and can wait or reschedule your appointment. If you are more than 15 minutes late to your assigned appointment, you will be rescheduled.

INSURANCE FILING: Dr. Koster is not a Medicare/Medicaid provider. Our office will file for all reimbursable services to both your primary and secondary insurance carriers. We will submit your insurance claim on your behalf and send you a statement the same day that we receive payment or non-payment. Please remember you are responsible for all deductibles, co-pays and non-covered service amounts. In addition, we are considered a specialist under your policy and our charges are not considered under the global Obstetrics policy but are considered outside of those reimbursement guidelines, therefore some of our fees may be applied to your deductible/coinsurance depending on your specific policy guidelines.

PRIVATE-PAY PATIENTS: If you do not have insurance or we do not accept your insurance we do offer a private-pay price for our services. If you have Medicare or Medicaid as your primary insurance we will not see you unless you make other arrangements with us. The private-pay discount is the same for every patient and will not be discounted further. We expect payment at the time the services are rendered. If you are unable to pay in full at the time of service you will need to make arrangements with our office prior to the appointment.

PAYMENT AGREEMENT: Dr. Koster is doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of statements we send to you and are expected to pay your copayment as well as any current outstanding balance on your account at the time services are rendered or upon receipt of your statement. We accept cash, VISA, Discover, MasterCard, AMEX and personal checks. There is a service charge for returned checks. We realize that financial difficulty is a reality and in such circumstances, we do offer payment plans. These arrangements must be approved by our Office Manager who may be reached at 972-981-8870. Patient care is our top priority, however payment is due for services rendered. If your account goes on unpaid for more than 60 days we may forward your account to our collections agency. A collections fee of 20% will be added to your responsibility upon submission of your debt.

RELEASE FOR ELECTRONIC TRANSMISSION OF INFORMATION

We are committed to the success of your medical treatment and care. In an effort to reduce the amount of paperwork you receive from our office, we can send correspondence to you via e-mail. Erin L. Koster MD, PA cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail.This document along with Erin L. Koster MD, PA "Notice of Privacy Practices" constitutes a notice of privacy practices for e-mail use as required by the Texas State Board of Medical Examiners.

AUTHORIZATION TO USE E-MAIL

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other heath care providers. I understand that receiving my health information by e-mail will not change the course of my medical care. I understand that it is my responsibility to provide the office of Erin L Koster, MD PA with the correct e-mail address and notify the office of any changes in e-mail address. If my handwriting is not legible, I understand that the office will not be responsible for documentation sent to the wrong e-mail address. I agree to the electronic mail transmission of my statements and any other documentation requested by me from the office of Erin L Koster, MD PA.

A copy of this authorization form will be provided at your request to you to keep for your records.

Erin L. Koster, M.D., P.A. **Notice of Privacy Practices**

Uses and Disclosures

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, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record 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 from 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 our practice. 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 to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

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 to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

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.

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

Practice 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. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. 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 the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. 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 address shown below. You will not be penalized or otherwise retaliated against for filing a complaint. You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person The name and address of the person you can contact for further information concerning our privacy practices is: Privacy Officer- Erin L. Koster, M.D., P.A. 6130 W. Parker Rd., Suite 512 Plano, TX 75093 972-981-8870.

Effective Date: This Notice is effective on or after April 14, 2003.