

MAKE CHECKS PAYABLE TO:



PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

Patient Name: ROBERT PLOCK

ADDRESSEE:

RETURN SERVICE REQUESTED 5 1

ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS, TX 75227-6043

We gladly accept (please mark box).		
<input type="checkbox"/> DISCOVER	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
NAME ON CARD		SECURITY CODE
CARD NUMBER		EXP. DATE
SIGNATURE		AMOUNT PAID
ACCOUNT #	BILLING DATE	BALANCE DUE NOW
2341966	08/01/13	1237.88

ANY PAYMENTS AND CHARGES AFTER THE ABOVE DATE  
WILL APPEAR ON THE NEXT STATEMENT

REMIT TO:

PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

### STATEMENT

TO ENSURE PROPER CREDIT, DETACH AND  
RETURN TOP PORTION WITH YOUR PAYMENT.

Thank you for choosing Pinnacle Pain Medicine for your healthcare needs. Your insurance company has processed your claim and the balance is now your responsibility. The outstanding balance is now due. Please pay this amount in full today. If you have questions, please call our Billing Office at (972) 663-8520.

#### ACCOUNT ACTIVITY:

Date	Provider	Description	Charge	Pay/Adj	Balance
05/29/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
06/25/13		UHC PMT DEDUCTIBLE AMOUNT		\$0.00	
06/25/13		HMO/PPO ADJ PATIENT BALANCE DUE		\$4458.74	\$565.26
05/29/13	ZACEK	01936 /5 PERC IMG GUID S	\$959.00		
07/09/13		UHC PMT DEDUCTIBLE AMOUNT		\$159.36	
07/09/13		COINSURANCE AMOUNT HMO/PPO ADJ		\$296.60	
07/03/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		\$503.04
07/29/13		UHC PMT COINSURANCE AMOUNT		\$395.68	
07/29/13		HMO/PPO ADJ PATIENT BALANCE DUE		\$4458.74	\$169.58
07/03/13	ZACEK	01936 /5 PERC IMG GUID S	\$822.00		
		PENDING INSURANCE		\$822.00	

#### ACCOUNT SUMMARY:

Patient Name ROBERT PLOCK  
Account Number 2341966  
Statement Date 08/01/13

Total Charges \$11829.00  
Insurance Payments (-) \$555.04  
Insurance Adjustments (-) \$9214.08  
Patient Payments (-) \$0.00  
Patient Adjustments (-) \$0.00

Insurance Pending \$822.00  
Patient Balance \$1237.88

**PLEASE PAY THIS AMOUNT: \$1237.88**

#### CURRENT INSURANCE INFORMATION:

##### Primary

Name UMR  
Member / ID Number XXX80912

##### Secondary

Name  
Member / ID Number

Totals: \$11829.00 \$9769.12 \$2059.88

#### CONTACT US:

For billing questions or an itemized list of charges, please call us at 972-663-8520. Our office hours are 8:30 A.M. through 5:00 P.M., Monday – Friday. Please see the back side of this statement for more information.

Written communication regarding any disputed bill, including an instrument tendered as full satisfaction of the bill, must be sent to:  
13601 PRESTON ROAD, SUITE 1000W, DALLAS TX 75240 ATTN: ACCOUNT DISPUTE RESOLUTION

MAKE CHECKS PAYABLE TO:



PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

Patient Name: ROBERT PLOCK

ADDRESSEE:

RETURN SERVICE REQUESTED 5 1

000946000  
03246000  
112114  
\*\*ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS, TX 75227-6043

We gladly accept (please mark box).		
<input checked="" type="checkbox"/> DISCOVER	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
NAME ON CARD		SECURITY CODE
CARD NUMBER		EXP. DATE
SIGNATURE		AMOUNT PAID
ACCOUNT #	BILLING DATE	BALANCE DUE NOW
2341966	09/02/13	CONTINUED

ANY PAYMENTS AND CHARGES AFTER THE ABOVE DATE  
WILL APPEAR ON THE NEXT STATEMENT

REMIT TO:

000946000  
03246000  
112114  
\*\*PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

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ACCOUNT ACTIVITY:

Date	Provider	Description	Charge	Pay/Adj	Balance
05/29/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
06/25/13		UHC PMT		\$0.00	
		DEDUCTIBLE AMOUNT			
06/25/13		HMO/PPO ADJ		\$4458.74	
		PATIENT BALANCE DUE			\$565.26
05/29/13	ZACEK	01936 /5 PERC IMG GUID S	\$959.00		
07/09/13		UHC PMT		\$159.36	
		DEDUCTIBLE AMOUNT			
		COINSURANCE AMOUNT			
07/09/13		HMO/PPO ADJ		\$296.60	
		PATIENT BALANCE DUE			\$503.04
07/03/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
07/29/13		UHC PMT		\$395.68	
		COINSURANCE AMOUNT			
07/29/13		HMO/PPO ADJ		\$4458.74	
		PATIENT BALANCE DUE			\$169.58
07/03/13	ZACEK	01936 /5 PERC IMG GUID S	\$822.00		
08/21/13		UHC PMT		\$396.48	
		COINSURANCE AMOUNT			
08/21/13		HMO/PPO ADJ		\$255.60	
		PATIENT BALANCE DUE			\$169.92
08/07/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
		PENDING INSURANCE			\$5024.00
08/07/13	HYDE	01936 /5 PERC IMG GUID S	\$822.00		
		PENDING INSURANCE			\$822.00

CONTINUED on next page...

ACCOUNT SUMMARY:

Patient Name  
Account Number  
Statement Date

Total Charges  
Insurance Payments (-)  
Insurance Adjustments (-)  
Patient Payments (-)  
Patient Adjustments (-)

Insurance Pending  
Patient Balance

PLEASE PAY THIS AMOUNT:

CURRENT INSURANCE INFORMATION:

Primary

Name  
Member / ID Number

Secondary

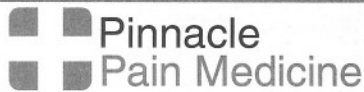
Name  
Member / ID Number

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MAKE CHECKS PAYABLE TO:



PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

Patient Name: ROBERT PLOCK  
ADDRESSEE:

RETURN SERVICE REQUESTED 5 1

ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS, TX 75227-6043

We gladly accept (please mark box).		
<input checked="" type="checkbox"/> DISCOVER	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
NAME ON CARD		SECURITY CODE
CARD NUMBER		EXP. DATE
SIGNATURE		AMOUNT PAID
ACCOUNT # 2341966	BILLING DATE 09/02/13	BALANCE DUE NOW 1407.80

ANY PAYMENTS AND CHARGES AFTER THE ABOVE DATE  
WILL APPEAR ON THE NEXT STATEMENT

REMIT TO:

PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

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Please pay this amount in full today. If you have questions, please call our Billing Office at (972) 663-8520.

ACCOUNT ACTIVITY:

Date	Provider	Description	Charge	Pay/Adj	Balance
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ACCOUNT SUMMARY:

Patient Name	ROBERT PLOCK
Account Number	2341966
Statement Date	09/02/13
Total Charges	\$17675.00
Insurance Payments	(-) \$951.52
Insurance Adjustments	(-) \$9469.68
Patient Payments	(-) \$0.00
Patient Adjustments	(-) \$0.00
Insurance Pending	\$5846.00
Patient Balance	\$1407.80

PLEASE PAY THIS AMOUNT: \$1407.80

CURRENT INSURANCE INFORMATION:

Primary

Name	UMR
Member / ID Number	XXX80912

Secondary

Name	
Member / ID Number	

Totals: \$17675.00 \$10421.20 \$7253.80

CONTACT US:

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PO BOX 650426  
DALLAS, TX 75265-0426

Patient Name: ROBERT PLOCK  
ADDRESSEE:

RETURN SERVICE REQUESTED 5 1

ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS, TX 75227-6043

We gladly accept (please mark box).		
<input checked="" type="checkbox"/> DISCOVER	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
NAME ON CARD		SECURITY CODE
CARD NUMBER		EXP. DATE
SIGNATURE		AMOUNT PAID
ACCOUNT # 2341966	BILLING DATE 10/01/13	BALANCE DUE NOW CONTINUED

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Date	Provider	Description	Charge	Pay/Adj	Balance
05/29/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
06/25/13		UHC PMT		\$0.00	
		DEDUCTIBLE AMOUNT			
06/25/13		HMO/PPO ADJ		\$4458.74	
		PATIENT BALANCE DUE			\$565.26
05/29/13	ZACEK	01936 / 5 PERC IMG GUID S	\$959.00		
07/09/13		UHC PMT		\$159.36	
		DEDUCTIBLE AMOUNT			
		COINSURANCE AMOUNT			
07/09/13		HMO/PPO ADJ		\$296.60	
		PATIENT BALANCE DUE			\$503.04
07/03/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
07/29/13		UHC PMT		\$395.68	
		COINSURANCE AMOUNT			
07/29/13		HMO/PPO ADJ		\$4458.74	
		PATIENT BALANCE DUE			\$169.58
07/03/13	ZACEK	01936 / 5 PERC IMG GUID S	\$822.00		
08/21/13		UHC PMT		\$396.48	
		COINSURANCE AMOUNT			
08/21/13		HMO/PPO ADJ		\$255.60	
		PATIENT BALANCE DUE			\$169.92
08/07/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
09/04/13		UHC PMT		\$395.68	
		COINSURANCE AMOUNT			
09/04/13		HMO/PPO ADJ		\$4458.74	
		PATIENT BALANCE DUE			\$169.58

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### ACCOUNT SUMMARY:

Patient Name  
Account Number  
Statement Date

Total Charges  
Insurance Payments (-)  
Insurance Adjustments (-)  
Patient Payments (-)  
Patient Adjustments (-)

Insurance Pending  
Patient Balance

### PLEASE PAY THIS AMOUNT:

### CURRENT INSURANCE INFORMATION:

Primary  
Name  
Member / ID Number

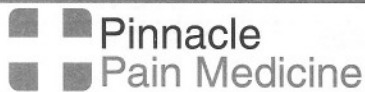
Secondary  
Name  
Member / ID Number

### CONTACT US:

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PINNACLE ANESTHESIA CONS.  
PO BOX 650426  
DALLAS, TX 75265-0426

Patient Name: ROBERT PLOCK

ADDRESSEE:

RETURN SERVICE REQUESTED 5 1

ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS, TX 75227-6043

We gladly accept (please mark box).		
<input checked="" type="checkbox"/> DISCOVER	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA
NAME ON CARD		SECURITY CODE
CARD NUMBER		EXP. DATE
SIGNATURE		AMOUNT PAID
ACCOUNT # 2341966	BILLING DATE 10/01/13	BALANCE DUE NOW 1741.54

ANY PAYMENTS AND CHARGES AFTER THE ABOVE DATE  
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REMIT TO:

PINNACLE ANESTHESIA CONS.  
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#### ACCOUNT ACTIVITY:

Date	Provider	Description	Charge	Pay/Adj	Balance
08/07/13	HYDE	01936 /5 PERC IMG GUID S	\$822.00		
09/10/13		UHC PMT		\$383.04	
09/10/13		COINSURANCE AMOUNT			
09/10/13		HMO/PPO ADJ		\$274.80	
		PATIENT BALANCE DUE			\$164.16

#### ACCOUNT SUMMARY:

Patient Name	ROBERT PLOCK
Account Number	2341966
Statement Date	10/01/13
Total Charges	\$17675.00
Insurance Payments	(-) \$1730.24
Insurance Adjustments	(-) \$14203.22
Patient Payments	(-) \$0.00
Patient Adjustments	(-) \$0.00
Insurance Pending	\$0.00
Patient Balance	\$1741.54

**PLEASE PAY THIS AMOUNT: \$1741.54**

#### CURRENT INSURANCE INFORMATION:

##### Primary

Name UMR  
Member / ID Number XXX80912

##### Secondary

Name  
Member / ID Number

Totals: \$17675.00 \$15933.46 \$1741.54

#### CONTACT US:

For billing questions or an itemized list of charges, please call us at 972-663-8520. Our office hours are 8:30 A.M. through 5:00 P.M., Monday – Friday. Please see the back side of this statement for more information.

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13601 PRESTON ROAD, SUITE 1000W, DALLAS TX 75240 ATTN: ACCOUNT DISPUTE RESOLUTION



July 23, 2013

Dear Robert Plock,

As of 9/1/2013, Dr. Tibor Racz will no longer be at the Heath office to service your pain management needs. In order to continue continuity of care please contact my office at (972) 572-6101 to make a follow-up appointment for a different location.

If you choose not to make a follow-up appointment the termination of our patient/physician relationship will be effective 30 days from the date of this letter. We urge you to go back to your original referring physician and secure another pain management physician. The Collin-Fannin County Medical Society (972) 529-5447, Dallas County Medical Society at (214) 948-3622, Denton County Medical Society (940) 566-3923, or the Tarrant County Medical Society at (817) 732-2825 have a free physician referral network with names and phone numbers of physicians in the area that may be able to care for you.

If you require emergency medical treatment within the thirty day period and prior to your securing another physician to assume your care, you may call our office and we will provide any emergency medical services required. At the end of thirty days, we will consider our professional relationship ended and assume you have established a professional relationship with another physician. When you have selected a physician, we will forward your medical records to him or her upon your request.

Enclosed is an authorization form that permits me to send your new physician a copy of your medical records. Please complete the form and return to me as soon as possible.

It has been a privilege to treat you in the past and wish you luck in your future pain management.

Sincerely,

A handwritten signature in cursive script, appearing to read "T Racz", is written over a horizontal line.

Tibor Racz, M.D.

Enclosure

**Pinnacle Partners In Medicine**  
**Request for Access to/Authorization for Use and Disclosure of Protected Health Information**

PATIENT NAME: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

I hereby authorize Pinnacle Partners In Medicine/Pinnacle Pain Medicine to disclose my protected health information as indicated below to: ☐ Mail to: ☐ Hold for pick up by:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- DATES: \_\_\_\_\_
- ☐ Discharge Summary \_\_\_\_\_
  - ☐ History & Physical Exam \_\_\_\_\_
  - ☐ Progress Notes \_\_\_\_\_
  - ☐ Lab Reports \_\_\_\_\_
  - ☐ X-Ray Reports \_\_\_\_\_
  - ☐ Medication Records \_\_\_\_\_
  - ☐ Detailed Bill \_\_\_\_\_
  - ☐ Other (specify content and dates): \_\_\_\_\_

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health or behavioral health
- ☐ HIV related information (AIDS related testing)

X

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

**PURPOSE OF DISCLOSURE:**

- ☐ Changing physicians ☐ Consultation ☐ Insurance/Workers' Compensation ☐ School ☐ Research ☐ At request of individual
- ☐ Legal (specify): \_\_\_\_\_
- ☐ Other (specify): \_\_\_\_\_
- ☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- ☐ I understand the expiration date of this authorization is ☐ \_\_\_\_\_ ☐ at end of research study; ☐ not applicable for ongoing research.
- ☐ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- ☐ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- ☐ By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- ☐ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it.
- ☐ I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- ☐ I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

Patient/Legal Representative Signature: \_\_\_\_\_ DATE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Records Received by: \_\_\_\_\_ DATE: \_\_\_\_\_ ID VERIFIED: \_\_\_\_\_

**FOR OFFICE USE ONLY**

DATE RECEIVED: \_\_\_\_\_ FEE COLLECTED: \$ \_\_\_\_\_ DATE EXTENSION REQUESTED \_\_\_\_\_ DATE FILLED: \_\_\_\_\_

**WE ARE UNABLE TO COMPLY WITH YOUR REQUEST BECAUSE:**

- ☐ The information you requested was not created by \_\_\_\_\_.
- ☐ Access is denied because such access may be harmful to you or someone else. You may request review of denial by contacting our Information Privacy Official.
- ☐ Access to certain portions of the record must be denied; a summary or portions of the record is supplied instead.

YOUR REQUEST FOR REVIEW HAS BEEN PROCESSED: An independent licensed health care professional has ☐ confirmed the need to deny your request ☐ recommended provision of access, as supplied

If you have any further questions or wish to file a complaint, please contact our Information Privacy Official. You may also request information about filing a complaint with the Secretary of Health and Human Services from our Information Privacy Official.

To contact our Information Privacy Official, call or write: Pinnacle Partners In Medicine, 13601 Preston Road, Suite 1000W, Dallas, TX 75240 (972) 715-5000