UROGYNECOLOGY
SAN ANTONIO

Name: **Date of Birth:**

Reason for your appointment:

Please list all medications along with dosage amounts:

Please list all medical problems:

Drug allergies:

GYN History:

Age of first menstrual cycle: _____

Age of menopause (if applicable): _____

Date of Last Menstrual Cycle: _____

Have you ever had an abnormal pap smear? _____

If Yes, When and what treatment was done: _____

Obstetrical History:

Please list all pregnancies, miscarriages or terminations, including type of delivery, complications, and year:

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Please list all surgeries along with the year performed:

_____ _____

_____ _____

Please list all hospitalizations along with year:

_____ _____

Family History:

Family Member	Diabetes	High Blood Pressure	Heart Attack	Stroke	Mental Illness	Cancer
Mom	☐	☐	☐	☐	☐	☐
Dad	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Maternal grandfather	☐	☐	☐	☐	☐	☐
Maternal grandmother	☐	☐	☐	☐	☐	☐
Paternal grandfather	☐	☐	☐	☐	☐	☐
Paternal grandmother	☐	☐	☐	☐	☐	☐

Has anyone in your family been diagnosed with Breast, Ovarian or Colon Cancer?

_____

Social History:

Do you smoke? _____

If yes, how much? _____

Do you exercise? _____

If yes, how many days a week? _____

Are you sexually active? _____

Do you drink alcohol? _____

If yes, how many drinks per month? _____

Do you use recreational drugs? _____

ASH DABBOUS, MD, FACOG
FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY

335 E. Sonterra Blvd. Suite #170 | San Antonio, Texas 78258
(o) 210.614.7744 | (f) 210.892.3886 | UroGynofSA.com

Urogynecology Of San Antonio

335 East Sonterra Blvd, Suite 170
San Antonio, Texas 78258
Phone (210) 614-7744 Fax (210)892-3886

OFFICE POLICIES

Office hours: Monday - Thursday 8: 30 am to 4:30 pm and Fridays 8:30am to 12:00 pm
Phone hours: Monday - Thursday 8:30 am to 4:30 pm and Fridays 8:30 am to 12:00 pm.

- **Please arrive 15 minutes prior to your scheduled appointment.**
- **Please bring your insurance card(s) and photo ID.**
- **Payment is due at the time services are rendered.**
- **Your insurance may require authorization for non-covered medications. Please allow two weeks for authorization to be initiated. Please provide our office with your prescription card to avoid any delays. Note that, depending on your insurance, the entire process may take 4-6 weeks.**
- **We understand that emergencies may occur; however, if you miss more than three appointments (no show or same-day cancel), you may be dismissed from the practice.**
- **You will be assessed a $50 cancellation fee if you cancel an appointment with less than 24 hours notice. You will be assessed a $500 cancellation fee if you cancel surgery less than 7 days in advance**
- **Cell phone use during your visit is prohibited.**
- **If you need a medication refill, an appointment will be required before a prescription is approved**
- **Inappropriate behavior toward staff, such as foul language, is prohibited and may result in dismissal from the practice.**

By signing below, I agree to adhere to the Urogynecology of San Antonio office policies outlined above.

Patient Signature	Patient Name	Date

Ash M Dabbous, MD
Lindsey A Jackson, MD
335 East Sonterra Blve, Suite 170
San Antonio, Texas 78258

UROGYNECOLOGY
SAN ANTONIO

Credit Card on File Policy

At Urogynecology of San Antonio, we require your credit card information be stored for future payments. Some, but not limited to, reasons your credit card would be used are as follows:

- Insurance payment for medical services rendered.
- Any balance that is applied to your account from insurance for services deemed to be patient responsibility.
- Payment plans for large balances
- No show or cancellation of appointments less than 24 hours in advance
- Cancellation of surgery less than 7 days in advance.
- Co-pay for virtual visits

By signing below, I authorize Urogynecology of San Antonio to keep a credit card on file for future payments and to charge all balances accrued on your account. I further understand that if a payment is denied by the credit card on file, I will NOT be able to schedule any further appointments until the balance has been paid in full. I also acknowledge that should my account remain unpaid it may be sent to a collection agency, and I may be dismissed from the practice. I am aware that if any of my personal information has changed, I am responsible to notify Urogynecology of San Antonio of the change(s) to ensure that they have the most current information to contact me if needed.

_____ _____

Signature of Patient or Responsible Party Name of Patient or Responsible Party

_____ _____

Date of Birth of Patient Date

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LINDSEY A. JACKSON, MD FACOG
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Patient Consent

Most office visits are subject to medical insurance filing. Any remaining charges are to be paid by the patient in the event a claim is not fully paid by insurance or is not subject to medical insurance filing.

Patient's Out-of-Pocket Responsibility

As GUARANTOR of this account, I hereby assume all financial responsibility for the payment of the services rendered to the named patient. I confirm the insurance information I have given to Urogynecology of San Antonio is current and accurate. Urogynecology of San Antonio has been given all insurance information and coverage pertaining to my treatment.

I understand that the information given to Urogynecology of San Antonio by my insurance company is not a guarantee of payment and is only an estimate of the amount that may be covered by insurance.

I understand that my Patient Responsibility, paid at the time of service, is only an estimate and the exact amount cannot be determined until final insurance payment has been received.

I understand that any outstanding charges will be charged to my credit card on file.

If I have questions about my insurance coverage or benefits, it is my responsibility to contact my insurance carrier directly.

I agree to make my estimated Patient Responsibility payment at the time of service.

I understand that any supplies or procedures not covered by my insurance are my financial responsibility.

I give Urogynecology of San Antonio consent to file all claims to my medical insurance.

I understand that a copy of this form will be provided to me upon request.

_____ _____

Patient Signature Date

_____ _____

Patient Name Date of Birth

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Lindsey A Jackson, MD
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San Antonio, Texas 78258

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Notice of Privacy Practices—Acknowledgement of Receipt

Patient Name_____

Patient Signature_____

Date of Birth_____

I acknowledge that I have reviewed Urogynecology of San Antonio Notice of Privacy Practice document. If you would like a copy of the Notice, please ask one of our staff members.

HIPPA Release Form

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information to:

Name	Relationship	Contact Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do not release this information to anyone (Please initial) _____

Patient Name_____

Patient Signature_____

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Preventative Services Notice

Preventive care services (well woman) include a routine physical exam and pap smear, if necessary. These visits help prevent health problems prior to symptoms occurring. They do not include tests or services to monitor/manage a condition or disease once it has been diagnosed.

I understand that if symptoms of acute or chronic problems are discussed at my preventive care visit, it is considered diagnostic; therefore, my office visit copay/ deductible may apply for the non-preventive part of the visit.

Patient Name_____

Date of Birth_____

Patient Signature_____

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