



## 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 5:00 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. If you are more than 15 minutes late for your appointment you will be rescheduled.
- Please bring your insurance card(s) and photo ID.
- Payment is due at the time services are rendered. **WE WILL CHARGE A 3% HANDLING FEE IF YOU CHOOSE TO USE A CREDIT CARD TO PAY. WE ACCEPT CASH, CHECK, CREDIT CARD (SUBJECT TO FEE), AND CARE CREDIT (SUBJECT TO FEE).**
- ALL FMLA forms are subject to a \$50 fee. Please allow 7-10 business days for processing.
- 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/reschedule 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. **AUDIO AND VIDEO RECORDING IS STRICTLY PROHIBITED WHILE INSIDE THE CLINIC WITHOUT THE EXPRESS PERMISSION OF YOUR PROVIDER.**
- If you need a medication refill, an appointment will be required before a prescription is approved
- Inappropriate behavior toward staff and/or providers, such as foul language, yelling, aggressive behavior, 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



## **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.

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Signature of Patient or Responsible Party

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Name of Patient or Responsible Party

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Date of Birth of Patient

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Date



## **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.**

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Patient Signature

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Date

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Patient Name

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Date of Birth

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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 \_\_\_\_\_

## **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 \_\_\_\_\_

**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:**

_____	_____
_____	_____

**Please list all surgeries along with the year performed:**


**Please list all hospitalizations along with year:**

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**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?**

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**Social History:**

<b>Do you smoke?</b>	
<b>    If yes, how much?</b>	
<b>Do you exercise?</b>	
<b>    If yes, how many days a week?</b>	
<b>Are you sexually active?</b>	
<b>Do you drink alcohol?</b>	
<b>    If yes, how many drinks per month?</b>	
<b>Do you use recreational drugs?</b>	