UROGYNECOLOGY
SAN ANTONIO

Office Policies

Office and Phone hours: Monday - Thursday 8: 30 am to 4:30 pm
Fridays 8:30am to 2:00 pm

• Please arrive 15 minutes prior to your scheduled appointment.

• Our office is a specialty clinic; therefore, every patient's plan of care is specialized to their concerns. Appointments can take up to 2 hours to complete. Your patience and understanding are greatly appreciated.

• Please bring your insurance card(s) and photo ID.

• Payment is due at the time services are rendered.

• **If you cancel your appointment less than 24 hours in advance or you No Show, there is a $75 fee charged to your credit card on file.**

• ALL FMLA forms are subject to a $50 fee. Please allow 7-10 business days for processing.

• Surgeries canceled within 1 week of surgery date are subject to a $500 cancellation fee.

• 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**.

• **Personal Cell phone use during your visit is prohibited. AUDIO AND VIDEO RECORDING IS STRICTLY PROHIBITED WHILE INSIDE THE CLINIC.**

• If you need a **medication refill please call the office**, an appointment may be required before a prescription is approved.

• **WE DO NOT ALLOW FAMILY MEMBERS TO ACCOMPANY THE PATIENT DURING THEIR TIME WITH THE PROVIDER, UNLESS DEAMED MEDICALLY NECESSARY OR THEY ARE NEEDED FOR TRANSLATION PURPOSES. DUE TO OUR LIMITED LOBBY SPACE PLEASE ONLY HAVE ONE PERSON ACCOMPANY YOU IF NEEDED.**

_____
Initials

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

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Patient Code of Conduct

Urogynecology of San Antonio is committed to providing high-quality care to our patients and communities in a safe and respectful environment that supports health and healing. To ensure our office locations are safe, caring, and inclusive, we ask that patients and visitors follow the example of our providers and associates by adhering to our **Patient Code of Conduct,** which includes the following:

- Everyone will be treated with kindness, dignity, and respect. Offensive comments about race, religion, gender, sexual orientation, or personal traits are not acceptable, and neither is the refusal to see a clinician or associate based on these traits.
- All patients and visitors will use respectful, appropriate language and behavior. Physical or verbal threats or assaults, suggestive or explicit words, phrases, gestures, or actions will not be tolerated.
- All patients and visitors will respect patient privacy and avoid disrupting other patients' care or experiences.
- **We do not allow personal recordings, video recording, or having family members on the phone or FaceTime calls during visits.**

If these guidelines are not followed:

- Patients may be terminated from the practice and referred out for their non-emergent immediate care. In cases of non-compliance, patients will have an opportunity to explain their perspective before a final decision is made.
- If a patient is terminated from our practice, they will have 30 days in which to find care at another facility,
- Visitors may be asked to leave and could be restricted from future visitation.

Every day, our providers, nurses, and associates are committed to providing the highest levels of care to our patients. Please show them the respect they deserve and that you expect as a patient or visitor.

Thank you for choosing Urogynecology of San Antonio and joining us in our commitment to ensuring a safe,caring, and inclusive environment for us all.

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Patient Insurance/Benefits 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. Patients' 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 further 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 further 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.

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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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.

HIPAA 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) _____

Email/Text Authorization

I hereby give permission for medical information to be emailed/and or texted to me. I agree that the phone number and email address listed below are personal and I further agree to have messages left and or sent to them.

Email Address: _____

Text Capable Phone Number: _____

_____
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Credit Card on File Policy

At Urogynecology of San Antonio, we require your credit card information to 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.

- Payment for virtual visits.

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 these changes to ensure that we have the most current information to contact me if needed.

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Medical Photography Consent Form

Photographs, digital images, and/or video recordings ("images") may be taken for medical documentation, treatment, identification or educational purposes. This form allows you to control how that images may be used.

Please read each section carefully and initial next to the uses you authorize.
A. Images for Medical Care (**NO** external disclosure)
Images may be taken and used only for medical evaluation, diagnosis, treatment, record-keeping, and internal clinical purposes.
I authorize images to be taken and used for medical care. Initial: _____

These images become part of my medical record and are protected under HIPAA and Texas privacy law.
B. Images for Office Education / Training

Images may be used within our office for education, case reviews, or quality improvement. Your face or any other recognizable feature **WILL NOT** be shown
Authorize? Initial: _____ Yes _____ No

C. Images for External Education
Images may be used for a medical conferences or teaching, **NO** identifying information (Your face and name) will be disclosed .
Authorize? Initial: _____ Yes _____ No

E. Conditions of Consent
- **I understand that I may withdraw this consent at any time by providing written notice, except to the extent images have already been used.**
- **I understand that I will not receive compensation for the use of these images.**
- **I understand that refusal to consent to photography not related to medical treatment will not affect my care.**
- **The facility will comply with all applicable privacy laws, including HIPAA and the Texas Medical Records Privacy Act.**

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Demographic Information

Legal Name:_____
Preferred Name:_____
Address:_____
_____
Email Address:_____
Text Capable Phone Number:_____
Preferred Pharmacy (Local)
Name:_____
Address:_____
_____
Phone Number:_____
Preferred Pharmacy (Mail Order – If Applicable)
Name:_____
Address:_____
_____
Phone Number:_____

Acknowledgement Of Polices Receipt

By signing below you acknowledge that you have read, understood and filled out all applicable areas of the office policies/procedures provided to you by our office.

Patient/Representative Name Patient/Representative Signature Patient DOB Date

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Name: **Date of Birth:**

_____

Reason for your appointment:

_____

Please list all medications along with dosage amounts:

_____

_____

_____

Please list medical conditions, include diagnosis that led to above prescriptions to be prescribed:

_____

_____

_____

_____

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 often? _____

Do you use recreational drugs? _____

_____

Patient Signature **Date**

Bladder Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe you? Select all that apply.

- ☐ Frequent urination – day, night, or both. Sudden or strong urge to urinate
- ☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - ☐ Accidental loss or leakage of stool
  - ☐ Constipation
  - ☐ Other _____

How long have you had these symptoms? _____

How frequently do you urinate? _____

How many times do you urinate at night (Nocturia)? _____

Do you currently catheterize? Yes/No How many times per day? _____

Average number of pads used daily? _____

Which behavior modifications have you tried? (circle all that apply)

Reduce fluid intake Caffeine reduction Kegel exercises Physical Therapy

Have you tried medications to help your bladder symptoms?

Please indicate any medications you have tried. If not, select "none"

- ☐ None
- ☐ DDAVP (Dexmopressin Acetate)
- ☐ Detrol LA (Tolterodine LA)
- ☐ Ditropan (Oxybutynin)
- ☐ Enablex (Darifenacin)
- ☐ Gelnique
- ☐ Gemtessa
- ☐ Myrbetriq
- ☐ Oxytrol
- ☐ Sanctura (Trospium)
- ☐ Toviaz (Festoterodine)
- ☐ Vesicare (Solifenacin)
- ☐ IC Medications {Elmiron, Elavil (Amitriptyline)}

Did these medications help your symptoms? (circle) Yes No

Are you still taking any of these medications? (circle) Yes No

If no, why have you stopped taking them?

- ☐ Did not help
- ☐ Side effects
- ☐ Too expensive
- ☐ other

Please list any prior bladder procedures:

_____

_____

Are you interested in learning more about additional treatment alternatives to bladder medications?

(circle) Yes No