STONE OAK
Womens Center
OBSTETRICS/GYNECOLOGY

Ash M. Dabbous, M.D. **Michelle A. Harden, M.D.** **Charles Robert Bigler, M.D.**

1139 East Sonterra Blvd, Suite 205, San Antonio, Texas 78258
Telephone: (210) 614-2229 Fax: (210) 614-2232

OFFICE POLICIES

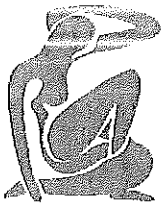
Office hours: Monday - Friday 8: 30 am to 5:00 pm.

Phone hours: Monday - Friday 9:00 am to 4:00 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 as they are only done on Thursdays. 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.
- If you need a medication refill, an appointment will be required before a prescription is approved.
- Cell phone use during your visit is prohibited.
- Switching between providers within the practice is not permitted.
- 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 Stone Oak Women's Center office policies outlined above.

Patient name Signature Date



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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 Stone Oak Women's Center (SOWC) is current and accurate. Stone Oak Women's Center has been given all insurance information and coverage pertaining to my treatment.

I further understand that the information given to SOWC 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 Stone Oak Women's Center 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/GUARANTOR SIGNATURE: _____ **DATE:** _____

Patient Name: _____

Guarantor Name: _____

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PATIENT WEB PORTAL

To Our Patients-

We now have a patient portal available for your use. This will allow you to have access to some of your medical information. This is a HIPAA secure site. You will be given a user name and password. If you become locked out of the system you will need to call our office and we will reset your account. The turn-around time is 48 hours for a new password.

☐ **Yes, I would like to be web – enabled.**

☐ **No, I do not desire to be web – enabled.**

☐ **No, I am already web-enabled.**

Patient Name (Print): _____

Patient Signature: _____

Date: _____

E-Mail: _____

Revised February 2015

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Notice of Privacy Practices—Acknowledgement of Receipt

Patient Name (please print): _____ Date of Birth: _____

I acknowledge that I have reviewed Stone Oak Women's Center Notice of Privacy Practice document. If you would like a copy of the Notice, please ask one of our staff members.

_____ _____
Signature of patient/ Representative/Parent or Guardian Date

_____ _____
Print Name of patient/Representative/Parent or Guardian Relationship to patient

HIPAA AUTHORIZATION FORM—Release of Information

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

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

Name	Date of Birth	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The release of information will remain in effect until terminated by me in writing.

_____ _____
Signature of patient/Representative/Parent or Guardian Date

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Preventive 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: _____ DOB: _____

Guarantor Name (if patient is a minor): _____

Patient/Guarantor Signature: _____ Date: _____

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New Patient Medical History

Name: _____ Date: _____

Reason for your appointment: _____

Drug allergies: _____

Please list all medical problems:

_____

_____

_____

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Please list all surgeries/hospitalizations:

_____

_____

_____

_____

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

_____

_____

_____

_____

CONTINUED ON REVERSE SIDE

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Gynecologic History

Age of first menses: _____

Age of menopause (if applicable): _____

First Day of Last Menstrual Cycle – (Date):_____

How long do your menstrual cycles last? _____

How heavy is the flow? ___ Heavy ___ Normal ___ Light

Have you ever had an abnormal pap smear? ___ Yes ___ No
If so, when? _____

Are you sexually active? ___ Yes ___ No
If so, are you using any form of contraception? ___ Yes ___ No

Social History

Do you smoke? ___ Yes ___ No
If so, how much? _____

Do you drink? ___ Yes ___ No
If so, how much? _____

Do you wear sunscreen? ___ Yes ___ No

Do you exercise? ___ Yes ___ No
If so, what type of exercise do you do? _____
How many times per week do you exercise? _____

Do you do your self-breast exams regularly? ___ Yes ___ No

Family History

Family Member	Alive/Deceased	Age	Medical Conditions
Mom			
Dad			
Siblings			
Paternal grandmother			
Paternal grandfather			
Maternal grandmother			
Maternal grandfather			
Children			
Maternal uncles			
Maternal aunts			
Paternal aunts			
Paternal uncles			