Las Colinas Obstetrics-Gynecology-Infertility Association, P.A.

Las Colinas Center for Women's Continence & Vaginal Reconstruction and Rehabilitation Center of Texas

3501 N. MacArthur Blvd., Suite 350 Irving, Texas 75062

Phone: (972) 257-5300 Fax: (972) 257-5322

Financial Policy

Payment: Payment is due at the time of service. If you have insurance, that means your deductible must be met, and you must pay all applicable co-pays or co-insurance at the time of service, unless previous arrangements have been made with our billing department. We accept all credit cards, checks, cash and third party financing. **Initials** _____

Insurance: If we are considered a preferred provider by your insurance carrier, your deductible must be met, and you must pay all applicable co-pays or co-insurances. Most misunderstandings regarding insurance coverage can be avoided if you understand what **your policy provides**. You will be held responsible for payment for any non-covered services. This includes services provided for any condition deemed pre-existing by your insurance carrier and is left unpaid. After your carrier has acknowledged receipt of your claim, they have thirty (30) days to pay it or contest it. If your claim is contested after the 30 days, we will seek your assistance in resolving any issues your carrier brings up. If your carrier requests more information from you, we ask that you respond to them immediately. If you do not, you will be held responsible for the full amount of the claim, with payment expected within ten (10) days of receipt of denial. This office will assist you and your Human Resources Department with any information that may be needed in the processing of your claims. **Initials** _____

Insurance Authorization/Assignment of Benefits: I hereby assign Las Colinas Ob-Gyn all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any non-covered services, services provided for pre-existing conditions, and for deductibles, co-pays and co-insurance amounts. **Initials** _____

Delinquent Accounts: Delinquent accounts will be reported to our collection service, IC systems. It is your responsibility to notify us of any anticipated late payments. **Initials** _____

Office Procedures/Surgeries: The patient or responsible party must make payments in advance or set up payment arrangements with our billing department before any office procedure or surgeries are performed. **Initials** _____

Cancellations: Patients will be charged $20.00 if they fail to cancel an appointment without 24 hour notice. **Initials** _____

No Show Patients: There is a $20.00 charge for any patient who fails to show for an appointment and no notification is given to our office. This appointment time could have been given to another patient in need of care. **Initials** _____

Prescriptions: There is a $10 fee for any duplication or replacement of written prescriptions. **Initials** _____

Labs or X-Rays: Patients are financially responsible for any labs or x-rays order by your physician. If you have any questions regarding your coverage, please contact your insurance carrier. **Initials** _____

Medical Records: Las Colinas Ob-Gyn will process your medical records request. There is a small fee for this service. If you have questions regarding their fees contact us at (972) 257-5300 Ext: 122 **Initials** _____

I have been offered the opportunity to ask questions regarding the above referenced policies. I understand the policies as stated above.

_____ _____

Patient/ Responsible Party Signature **Date**

Cc: Patient **Copy given to patient by** _____

(Initials here)

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Patients:

To protect our pregnant patients from exposure to childhood disease, along with the hazards that exist for children in the doctor's office, we respectfully request that arrangements be made for small children when an appointment is made with the doctor.

_____
Patient Signature

_____
Print Patient Name

_____
Date

John J. Zavaleta, R.Ph., M.D.
Diplomate American Board of
Obstetrics & Gynecology
Board Certified

John R. Hanson, M.D.
Gonzalo Garcia, M.D.
Annie Saldaña, PA-C

LAS COLINAS OBSTETRICS-INFERTILITY ASSOCIATION, P.A.
3501 N. MACARTHUR, SUITE 350
IRVING, TX 75062

Office: (972)257-5300 Fax: (972) 257-5322

I, _____, give permission to Dr. John J. Zavaleta, M.D. or any of associates/staff to release any information regarding my medical history or billing records to anyone listed below.

_____

_____ _____
Patient Signature Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed the offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

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Name: _____ Pt. ID#_____ Date_____

Patients: Please complete the following short questionnaire. Doing so will help us to offer you the most thorough medical care available.

I sometimes urinate more than 7 times per day.	Yes	No
I sometimes get up more than twice at night to urinate.	Yes	No
I sometimes leak urine before reaching the bathroom.	Yes	No
I wear pads because I leak urine and wish I didn't.	Yes	No
My bladder does not feel empty after I urinate.	Yes	No
It takes time to start urinating.	Yes	No
I sometimes leak urine if I cough, sneeze, laugh, or exercise.	Yes	No
I have to push or bend forward to urinate	Yes	No
I sometimes pass urine when I push to have a bowel movement.	Yes	No
I sometimes have less than 3 bowel movements per week.	Yes	No
I sometimes have to push excessively or spend a long time trying to have a bowel movement.	Yes	No
I have to take fiber or laxatives to stay regular.	Yes	No
I have pressure or bulging in the vagina or rectum.	Yes	No
I have accidentally passed gas, liquid, or solid stool from the rectum.	Yes	No
I sometimes feel my rectum is not empty after a bowel movement.	Yes	No
I have low back pain and/or knee pain.	Yes	No
I feel my periods are heavy, painful, or irregular.	Yes	No
I am done having children and would like to discuss long-term birth control options.	Yes	No
I feel like I have a low sex drive.	Yes	No
It is difficult or takes longer for me to orgasm.	Yes	No
I sometimes have pain with sex.	Yes	No
I sometimes have vaginal air during sex.	Yes	No
Are you interested in weight loss management?	Yes	No

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John R. Hanson, M.D.
Annie Saldaña, PA-C, MPAS

Pt Name: _____ Pt Chart #: _____

Questionnaire:
The Physical Symptoms of Hypothyroidism

Ref. *The Thyroid Solution* by: Ridha Arem, M.D.

Has your hair become dry, or are you losing your hair?	Yes	No
Have your menstrual periods been heavy in recent months?	Yes	No
Have you been suffering from joint aches and pains?	Yes	No
Are your nails brittle?	Yes	No
Have you been getting muscle cramps?	Yes	No
Have you noticed a continuous weakness in your muscles?	Yes	No
Has your skin been dry?	Yes	No
Have your face and eyes been puffy?	Yes	No
Have you been experiencing unusual coldness?	Yes	No
Have your gained more than five pounds?	Yes	No
Has your skin become coarse?	Yes	No
Have you been constipated?	Yes	No
Have you noticed in recent months a milky discharge from your breasts?	Yes	No
Do you sweat less?	Yes	No
Has your voice become hoarse?	Yes	No
Do your fingers tingle?	Yes	No
Has your hearing gotten worse?	Yes	No
Has your heartbeat been slow?	Yes	No
Have you been experiencing stiffness?	Yes	No
Have you been fatigued?	Yes	No
Have your eyes been dry?	Yes	No
Have you been experiencing shortness of breath during exercise or reduced tolerance to exercise?	Yes	No
Have you had lower interest in sex?	Yes	No
Have you had insomnia?	Yes	No
Have you had puffy skin?	Yes	No
Have you developed acne?	Yes	No

See if any of the following statements ring a bell:

You're pushing yourself to get through the day.	Yes	No
Activities you used to love are such a strain that you've stopped enjoying them.	Yes	No
You've stopped exercising, socializing, etc., because you can't spare the energy.	Yes	No
You crash in the afternoon, wanting to do nothing but sleep.	Yes	No
When you get home from work, you feel so dead tired that all you can do is sleep.	Yes	No