Marissa N. Largoza M.D.
OBGYN

Patient Information Form

Demographics (Complete in full): Today's Date _____

Name _____ Age_____ Date of Birth_____
Address_____ HM Ph # _____
City _____ State_____ Zip _____ Cell Ph# _____
SSN _____ Single_ Separated_ Married_ Divorced_ Wk Ph# _____
Race: _____ Ethnicity: *Hispanic / Non-Hispanic* Religion: _____
Gender: _____ Primary Language: _____
E-mail address: _____ (necessary for billing statements)
Employment Information:
Employer's Name_____ Occupation_____
Employer's Telephone ( ) _____ Ext: _____
Emergency Contact Information:

Name_____ Telephone ( ) _____ Relation_____

Name_____ Telephone ( ) _____ Relation_____

PREFERRED PHARMACY: _____ **Location/cross streets** _____

Reason for consultation: _____
List any allergies to medication: _____

Insurance Information:

Primary Insurance Name _____ Insured SS#: _____
Name of Insured _____ Insured's Date of Birth _____
Employer's Name_____ Employer's Telephone ( ) _____
Secondary Insurance Name_____ Insured SS#: _____
Name of Insured _____ Insured's Date of Birth _____
Employer's Name _____ Employer's Telephone ( ) _____

Assignment of Benefits

I, the undersigned, understand that I am financially responsible for all charges whether or not my insurance pays. I hereby authorize the release of all information necessary to secure payment. I hereby assign all Medical/surgical benefits to Marissa N. Largoza, M.D., P.A. I further understand a 60% fee will be added to my account in the event it is necessary for my account to be forwarded to a Collection Agency.

Signature _____Date _____

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Office Policies:

Welcome to our office and thank you for choosing Marissa N. Largoza, M.D., for your gynecological and obstetrical care. We strive to create a warm and comforting environment where your health needs are met with compassion and expertise. To ensure a smooth and efficient experience we believe clear communication and mutual understanding are essential in building a strong patient-provider relationship. Please familiarize yourself with the following policies:

1. **PAYMENTS**: All applicable fees such as: deductible, coinsurance, and co-pays must be paid at the time of service. Our office accepts cash, Visa, MasterCard, Discover, American Express and Care Credit.

2. **HMO & PPO REFERRALS**: If your insurance policy requires a written authorization from your **P**rimary **C**are **P**hysician for an appointment, you must notify your PCP to process the request prior to your visit.

3. **INSURANCE VERIFICATION**: As a policy holder, it is **your** responsibility to call your insurance and verify that the physician you selected is a provider of your plan. You must provide your insurance card **(we do not accept copies or handwritten information)** at every visit to verify the insurance carrier otherwise you will be expected to pay for your visit. Any benefit verification provided to you by our office is information received from **YOUR** insurance carrier who states "the benefits or estimation given are not a guarantee of payment" which means verification or pre-authorization is not a promise of payment. Ultimately, you are responsible for your account balance.

4. **STATEMENT POLICY:** To provide efficient and environmentally friendly services to our patients, statements will be sent electronically by text and/or to the email address provided by the patient. Patients are responsible for ensuring that their phone number/email address on file is accurate and up to date. Patients who wish to Opt-Out of electronic statement delivery should contact our office and request a change in their statement delivery.

5. **MEDICATION REFILLS**: When requesting a refill, contact your pharmacy first, they will call our office to receive authorization. Please call for a refill when you still have at least one week's supply of medication. Keep in mind the refill process may be delayed by insurance, a holiday, or the weekend. Refills are not considered an emergency.

6. **APPOINTMENT TIME**: We ask you to arrive on time for your scheduled appointment. If you arrive after your scheduled appointment time you may be rescheduled. At times, your physician may run late due to unscheduled deliveries, we ask for your patience.

7. **CANCELLATIONS**: A $50.00 fee will be assessed for any cancellations within 24 hours of your scheduled appointment. After 3 missed appointments you may be terminated from her practice, at the physician's discretion.

8. **AFTER-HOURS CARE**: In case of an emergency, please dial the main office number (210) 692-0831. Our answering service will take your message and locate the physician on call. The physician on call will return your phone call as soon as possible.

9. **INFORMATION CHANGES**: Please provide our office with **ANY** changes regarding your address, phone number, employment information, and medical insurance as soon as possible.

10. **NON-COMPLIANCE**: Our office reserves the right to discontinue care due to non-compliance with your plan of treatment or any of the policies of this office.

I _____, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and responsibilities.

_____ _____ _____

Patient Name Patient/Guardian Signature Date

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Annual Visit (Wellness Exam) Notice:

For clarification purposes we would like for you to read the following information regarding your annual visit to establish what an "annual visit" includes.

- **Patients in Childbearing Years:** an Annual ONLY Includes the following: -PAP smear, breast exam, and continuation of birth control method. If birth control is established at the annual visit this will be charged as a separate visit.
- **Patients in Pre-menopausal Years:** an Annual ONLY Includes the following: -If the patient is 40 years and older, she will receive a PAP smear, breast exam, continue Hormone Replacement Therapy (HRT) or Birth Control Method (BCM), and mammogram order. If birth control or hormone replacement is established, you will be charged a separate visit. -If the patient is 50 years and older, she will receive a PAP smear, breast exam, mammogram order, and bone mineral density scan order as needed. If hormone replacement is established, you will be charged a separate visit.

ANY problem or concern (i.e. discharge, painful intercourse, irregular bleeding, UTI's etc.) discussed and/or treated at "annual visit" that is not included in the above description WILL be charged as a separate visit.

General Physical Health Exams may or may not include a pap smear. If another physician has billed your insurance for a general physical, your annual/wellness exam may not be covered by your health insurance. Patients are responsible for 100% of the fee if their insurance does not cover their annual/wellness exam.

Medicare Patients: Medicare ONLY pays for annual visits every TWO years. If you are seen for an annual visit within that two-year time span, YOU will be held responsible for payment at the time of service UNLESS your annual visit is covered by your secondary insurance.

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date

Laboratory Notice:

I understand the laboratory test(s) or any diagnostic testing that I and/or the doctor have requested may not be covered under my insurance plan. I understand it is my responsibility to confirm coverage of these tests with my insurance carrier. I also understand my physician is not responsible for handling any portion of the charges incurred by the request for blood work or pathology. I understand that it is my responsibility to inform this office which laboratories are part of my health insurance network. I understand that signing this notice confirms I am aware of my responsibility for any charges incurred in laboratory tests requested by me or my physician. I further understand that this office does NOT provide any laboratory/pathology services and that I know I will receive a bill from another facility. I also understand that I have the right to REFUSE any testing requested by my provider.

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date

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Protected Health Information (PHI)

You may contact me by phone at the following (at the numbers listed in your patient information):

□ Any/All Numbers provided □ Home Phone □ Work Phone □ Cell Phone
□ I do not wish to be contacted by phone

Please let us know how you prefer that we contact you (except for appointment confirmations)

You may leave a message regarding my medical information on an answering machine or voicemail at the following:

□ Any/All Numbers provided □ Home Phone □ Work Phone □ Cell Phone
□ I do not wish to be contacted by phone

Using the methods of communication selected above please list the person(s) to whom you permit Marissa N. Largoza, M.D.P.A.to discuss and/or release your Protected Health Information and their relation to patient (Ex. Parent, Sister, Aunt, Grandmother, Friend etc.)

□ I do not wish any person(s) to receive my PHI : *PHI will ONLY be provided to PATIENT ONLY!! Relatives/Parents/Spouses will not be given PHI if box is checked.*

□ I authorize the following Person(s) to receive my Protected Health Information (PHI): *Please List the person(s) Name and Relationship to the patient. Do NOT include medical professionals who are involved with your patient care.*

Name	Relationship to Patient	TYPE OF PHI
		□Medical Only □Financial Only □Both Medical/Financial
		□Medical Only □Financial Only □Both Medical/Financial
		□Medical Only □Financial Only □Both Medical/Financial
		□Medical Only □Financial Only □Both Medical/Financial
		□Medical Only □Financial Only □Both Medical/Financial

I request the following restrictions to the release OR non-release of my Protected Health Information (PHI) to the person(s) listed above:

I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices for Marissa N. Largoza, M.D., P.A. and ask questions. Notice of Privacy Practices available online, in the office and in the patient portal.

My Signature below indicates understanding that restrictions and agreements made in this consent will not expire or terminate unless either party notifies the other party, in writing, of their withdrawal of the agreements and restrictions contained in this consent. The signature below indicates understanding that, in the event either party terminates this consent, the PHI for dates in which this consent was valid will remain protected under the terms of agreement and restriction of the then in effect consent.

_____ _____ _____
Patient Name Patient/Guardian Signature Date

_____ _____ _____
Staff Name Staff Signature Date