Marissa N. Largoza M.D, P.A.
Rene Saenger M.D, P.A.
Kelly J. Morales M.D., P.A.

Congratulations on your Pregnancy!

This is to acknowledge I have received the following brochures:

- Information on Umbilical Cord Blood Banking and Donation
- 10 questions about pregnancy and HIV
- Information for Parents of Newborns Packet

Also to inform me of the following tests available to me:

- Cystic Fibrosis testing
- Genetic testing (available in two ways):
  1st Trimester Screening with a perinatologist OR
  2nd Trimester Screening done between 15-20 weeks

As of January 1, 2010, the State of Texas requires you to be tested **again** for HIV, RPR and Hepatitis B during the last trimester of your pregnancy (starting at 28 weeks).
If you have any questions, please feel free to ask your physician or medical staff.

_____ _____

Print Name Date

Marissa N. Largoza, M.D., P.A.
Rene Saenger, M.D., P.A.
Kelly J. Morales, M.D., P.A.

Call Group Information

Thank you for choosing our office for your obstetrical and gynecological care!
As you may have noticed we are an office with three female physicians, a female Nurse Practitioner as well as an all-female staff. Our physicians practice in the Methodist Plaza Building as it allows them to walk to Methodist Hospital and personally deliver or treat their patients. On occasions you may need medical attention after business hours or during the weekend at which time one of the "call group" physicians will take care of your medical needs. There are 9 physicians who form part of the call group one of which is a male. To follow is a list of all the physicians in the call group:

Karen Hasty, MD
Roberta Krueger, MD
Marissa N. Largoza, MD
James Lovell, MD
Patience Miller, MD
Kelly J. Morales, MD
Nancy Rector-Finney, MD
D. Rene Saenger, MD
Patricia K. Brougher, MD

The call group physician's alternate days to take call after hours or on the weekend which means you may have any of the above physicians call or care for you.

My signature below confirms I understand the information explained above. I also understand there will always be a physician available to me after hours and on weekends however it may be any of the physicians named above.

_____ _____
Patient Signature Spouse Signature

_____
Date

_____ _____
Staff Member Date

Marissa N. Largoza, M.D., P.A.
Rene Saenger, M.D., P.A.
Kelly J. Morales, M.D., P.A

Medicaid Disclosure

I understand Dr._ Marissa Largoza is accepting me into her practice as

a private pay/private insurance patient for the period of _____ to _____.

I understand I will be responsible for paying any and all services I receive.

The provider indicated above will not bill Medicaid as primary or secondary

Insurance for any services provided.

_____

Patient Signature

_____

Date

Marissa N. Largoza, M.D.
Rene Saenger, M.D.
Kelly J. Morales, M.D.

Laboratory Notice

Please Initial

___ 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 Signature

_____
Date

_____
Witness

Marissa N. Largoza, M. D., P. A.
D. Rene Saenger, M. D., P. A.
Kelly J. Morales, M.D., P.A.

Our Office Policy

Welcome to our office and thank you for choosing one of our physicians for your medical care. The following are our office policies. As a patient you are expected to respect and agree to the following:

Please Initial

_____ 1. **PAYMENTS**: All applicable fees such as: deductible, coinsurance, and co-pays must be paid at the time of service. Our office accepts Cash, MasterCard, Visa, Discover 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 hand written information)** at every visit to verify the insurance carrier otherwise you will be expected to pay for your visit.

_____ 4. Any benefit verification provided to you by our office is information received from **YOUR** insurance carrier who state "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.

_____ 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 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 do unscheduled deliveries, we ask for your patience.

_____ 7. **CANCELLATIONS**: If it is necessary to cancel your appointment, we ask that you call at least 24 hours prior to your scheduled appointment. If you miss three appointments, at the physician's discretion, you may be terminated from her practice.

_____ 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/Guardian Signature Date

_____ _____

Printed Patient/Guardian Name Witness Initials and Date

Dr. Marissa N. Largoza Dr. Rene Saenger Dr. Kelly J. Morales

Office Policy for Annual Visits

Thank you for selecting one of our physicians as your provider for your gynecological needs.

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

Women in Child Bearing Years an Annual Includes:
-PAP smear, breast exam, and continuation of birth control method.
If birth control is established at annual visit this will be charged as a separate visit.

Women in Pre-menopausal Years an Annual Includes:
-If patient is 40 years and older she will receive a PAP smear, breast exam, continue Hormone Replacement Therapy (HRT) or Birth Control Method (BCM), mammogram order and rectal exam for fecal occult blood (checking for blood in stool).
If birth control or hormone replacement is established you will be charged a separate visit.
-If patient is 50 years and older she will receive a PAP smear, breast exam, mammogram order, rectal exam for fecal occult blood (checking for blood in stool) 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 treated at "annual visit" that is not included in the above description **WILL** be charged as a separate visit.

_____ _____
Patient Signature Date

~ ~ ~ MEDICARE PATIENTS ONLY ~ ~ ~

____ Medicare **ONLY** pays for annual visits every **TWO** years. If you are seen for an annual 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.

By signing this form I confirm I understand the information stated above.

_____ _____
Patient Signature Date

PATIENT INFORMATION FORM

Demographics (Complete in full):

Today's Date _____

Name _____ Age_____ Date of Birth_____

Address_____ HM Ph # _____

City _____ State_____ Zip _____ Cell Ph# _____

SSN _____ Marital Satus Single Work Ph# _____

Race: _____ **Ethnicity** Unknown **Gender**: Female **Religion**

Primary Language: _____

E-mail address: _____ **(necessary for appt confirmation)**

Employment Information:

Employer's Name_____ Occupation_____

Address: _____ City_____ State: ____ Zip_____

Employer's Telephone ( ) _____ Ext: _____

Emergency Contact Information:

Name_____ Telephone _____ Relation_____

Name_____ Telephone _____ Relation_____

PREFERRED PHARMACY: _____**Telephone** _____

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., Rene Saenger, M.D., P.A. and/or Kelly J. Morales, 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** _____

Please let us know how you prefer that we contact you (except for appointment confirmations which will be provided to you by email):
(Please mark YES, NO, OR N/A)

1. Please indicate where we may contact you by phone (at the numbers listed in your patient information).
Home: Yes

Work: Yes

Cell Phone: Yes

2. May we leave a message regarding your medical information on an answering machine or voice mail:
Home: Yes
Work: Yes

Cell Phone: Yes

3. May we leave a phone message regarding your Protected Health Information with any of the persons listed below:
Home:

Work:

Cell Phone:

Using the methods of communication selected above please list those person(s) to whom you permit □Marissa N. Largoza, M.D.P.A., □Rene Saenger, M.D., P.A. and/or □Kelly J. Morales, M.D., P.A. to discuss or release your Protected Health Information and their contact information.

_____

_____

_____

I acknowledge that I have received a copy of □Marissa N. Largoza, M.D., P.A., □Rene Saenger, M.D., P.A. **and/or** □Kelly J. Morales, M.D., P.A. Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Patient/Patient Representative Name Signature

_____ _____
Relationship to Patient Date