CYPRESS OBGYN

10680 Jones Road, Suite 600
Houston, TX 77065
(P) 281-477-0417, (F) 281-477-0166

Patient's Legal Name: Last: First Ml:			Date of Birth:
Permanent Address: Street:			
City: State: Zip:		Social Security Number	Marital Status: Single/Married/Divorced
Home phone:	Mobile Phone:	E-mail Address (if applicable):	
Emergency Notification:	Phone:	Relationship to Patient:	
Policy Holder's Name (if other than self)	Date of Birth:		

I. knowing that I am experiencing a condition that requires diagnostics, medical or surgical treatment do herby voluntarily consent to such procedures and care to such medical, surgical, or other services under the general and/or specific instructions Of Dr. Oanh Bui, or her designee, as is necessary to her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments of examination by Dr- Oanh Bui. I authorize the release of any medical information necessary for the processing of insurance. I authorize the release of any medical information necessary to the physician to whom I have referred. A photocopy of the assignment is to be considered as valid as an original.

I have received the Notice Privacy Practices and I have been provided an opportunity to review it.
For any NORMAL Labs, X-Ray, U/S, etc.… How would you like for us to contact you?

() Text Message _____

() Email_____

Signature:_____ Date: ___/___/___

CYPRESS OBGYN

10680 Jones Rd, Suite 600. Houston, TX 77065. (P) 281-477-0417, (F) 281-477-0166

Email Address: _____
Pharmacy Name: _____
Pharmacy Phone Number: _____
Pharmacy Address: _____
Drug Allergies: _____No Know Allergies: ____
Other Allergies: _____

Race:

- Asian
- White
- Black or African American
- Mexican or American Indian
- Other Race_____
- Decline to Specify

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Refuse to Report

Language:

- Spanish
- English
- Vietnamese
- Other_____

Patient Signature: _____ Date: _____

CYPRESS OBGYN

10680 Jones Road, Suite 600
Houston, TX 77065
(P) 281-477-0417, (F) 281-477-0166

Attention Patient.

Cancellation/ Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients need of medical care.

Cancelation of an appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to attend appointment. This time will be reallocated to someone who is urgent need of treatment. If it is necessary to cancel your schedule appointment, we require that you call at least 24 hours in advance and calling early in the day is appreciated. Appointment are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care**. If you canceled more than 3 times, we would have a terminate you as our patient.**

No show policy

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-show" inconveniences those individuals who need access to a medical care in a timely manner. A failure to present at the time of scheduled appointment will be recorded in the patient's chart as "no-show**". If you miss your appointment more than 3 times, we would have to terminate you as our patient.**

No-show/ Missed Appointment/ Cancellation Policy:

1st Time: Verbal Reminder

2nd Time: A $25.00 fee charged

3rd Time: Termination / Discharge of Care

Print Name _____
Signature _____ Date: ____/____/____

CYPRESS OBGYN

10680 Jones Road, Suite 600
Houston, TX 77065
(P) 281-477-0417, (F) 281-477-0166

Financial Agreement:

Welcome to our office, please take a moment to review our financial policy.

Although we accept most insurance plans, it is the responsibility of the patient to be familiar with his or her benefits. Some procedures, ultrasounds, injections, and medical supplies distributed from our office may not be covered. Our office will make every attempt to verify insurance benefits prior to your visit. In the event that your insurance does not cover these services, or if benefits or eligibility is unobtainable, you will be responsible for any charges incurred.

ATTENTION HMO/MEDICAID PATIENTS: in order for your insurance to consider any medical services provided by the office, it is your responsibility to have an active referral from your primary care provider on file. In the event that there is not an active referral on file, we request that payment be made at the time of service.

ATTENTION PATIENTS APPLYING FOR MEDICAID AT A LATER DATE: if patient acquires Medicaid at a later date, the patient will not receive a refund, but they will receive an IN-HOUSE CREDIT for a later date. The patient is able to apply this credit towards any products or services that the office offers. The patient is responsible for notifying us once Medicaid is acquired.

Payment is due at time of service; this will include any deductibles, office visit co-pays, and coinsurance amount due. If payment is not received in timely manner, our office retains all rights to transfer your account to a collection agency.

Thank you for choosing Women's Healthcare for your healthcare needs. Please be assured that our staff will answer any questions you may have regarding our office policy.

I, _____, HAVE READ AND DO AGREE TO THE TERMS REGARDING THIS FINANCIAL AGREEMENT.

SIGN: _____ DATE:____/____/____

PRINT NAME:_____

RELATIONSHIP TO PATINET: _____

CYPRESS OBGYN

10680 Jones Road, Suite 600
Houston, TX 77065
(P) 281-477-0417, (F) 281-477-0166

Patient Authorization for Access to Protected Health Information

I give permission for the following people to have access to my protected health information and reserve the right to revoke this at any time by notifying the office.

() Spouse: _____ Phone Number: _____

() Children:_____ Phone Number: _____

() Children:_____ Phone Number: _____

() Children:_____ Phone Number: _____

() Other Relative: _____ Phone Number: _____

I Would like to have messages regarding:

() Appointments () Test Results

Be given to me by:

()Home phone: _____ () Cell phone: _____

() Work phone: _____ () Fax: _____

() NO CONSENT to release information to anyone

Print Name: _____

Signature: _____

Date: _____/_____/____

CYPRESS OB/GYN

10680 Jones Rd, Suite 600. Houston, TX 77065

FINANCIAL PRACTICE POLICY

Dear Patient:

As a courtesy, Women's Healthcare verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received

It is the policy of Women's Healthcare that payment is due at the time of service unless other financial arrangements are made in advance. You will be required to set up a payment plan if for some reason you are unable to pay at the time of service. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit prior to being seen. The Floor Supervisor at your location will explain this information to you prior to your first visit and any subsequent visits thereafter. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund accordingly.

If you are covered by health insurance with wellness and/or maternity benefits, we will be happy to bill your insurance. Please provide your insurance information (primary and secondary) to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan or you may have exhausted a particular benefit such as Ultrasounds and Immunizations. You will be given an opportunity to pay for that particular test before having the test done. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred unless your health plan specifies otherwise. Your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contact your insurance and check into your coverage for Obstetrics and Gynecology and familiarize yourself with your summary plan description. Do not assume that you will not owe anything if you have more than one insurance policy.

I have understood and read the above foregoing and if I have any questions, I have been given the opportunity to have those questions and/or concerns addressed.

We appreciate the opportunity to care for you and your loved ones.

Patient Signature: _____ Date: _____/____/____