6705 Heritage Pkwy Ste 102 Rockwall, TX 75087 Phone: 972.722.2526 Fax: 972.722.2528

PATIENT

Last Name:	
First Name:	
Preferred Name:	
Middle Name:	
Previous Name:	
Sex:	
Date of Birth:	
SSN: (for billing)	
Address:	
Address (ctd):	
Zip Code:	
City:	
State:	
Home Phone Number:	
Cell Number:	
Consent to Text:	
Work Number:	
Email Address:	
Contact Preference:	
Language:	
Race:	
Ethnicity:	
Marital Status:	
Pharmacy:	
How did you hear about us: _____	

Guardian

Last Name:	
First Name:	
Phone Number:	

Emergency Contact

Name:	
Relationship:	
Home Number:	
Cell Number:	

Next of Kin

Name:	
Relationship:	
Phone:	

Employment

Employer Name:	
Employer Phone:	
Job Title:	

Insurance

Insurance Name:	
Insurance Address:	
Insurance Phone #:	
Insurance ID #:	
Insurance Group #:	
Primary on Insurance:	
Primary Date of Birth:	
Primary SS #:	
Relationship to Patient:	

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release: I, the undersigned, authorize payment of medical benefits to GLOW, Dr. Theresa M Conyac, MD, for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize GLOW to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

PATIENT SIGNATURE: _____ DATE: _____

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Room:_____ Patient:_____ Age:_____ UPT:_____ UA:_____

WT:_____ HT:_____ BP:_____ Pulse:_____ OB:_____wks, _____days EDD:_____

__PLEASE FILL OUT AND COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY. IF IT DOES NOT APPLY TO YOU PLEASE PUT N/A__.

__Problems/Reason for visit__: **__Allergies__:**

__Medications__: **__Pharmacy__:**

__Gyn History__: Date of last pap:_____ HPV vaccine:Yes No Sexually active: Yes No
Sexual problems:Yes No STIs/STDs:Yes No Age at first child:____ On BCP's at conception:Yes No
Most recent mammogram: _____ Abnormal Pap: Yes No Flow: Light Moderate Heavy
Menses monthly: Yes No Age at 1st period:_____ Age at menopause:___
Date of last colonoscopy:_____ Date of last period:_____ Hormone replacement therapy: Yes No

__Current birth control method__: _____ __Desired birth control method__: _____

Pregnant Seeking Pregnancy Partner Vasectomy Menopause Sterilization Tubal Ligation BCPs
IUD Condoms Depo-Provera Vaginal Ring Hysterectomy Abstinence Diaphragm
Implant Patch Spermicide Withdrawal Ablation Sponge Cervical Cap

__Obstetric History__:
Total:___ Full term:___ Premature:___ Abortions induced:___Abortions spontaneous:___ Ectopics:___Multiple births:___Living:___

__Past Pregnancies__:
1.Fetus Date: _____ _____lbs_____oz Gestational age : _____weeks _____day Labor length hrs: _____
Anesthesia: _____Preterm labor: Yes No Delivery site: Vaginal / C-Section Gender: M / F
Complications: Yes No
1.Fetus Date: _____ _____lbs_____oz Gestational age : _____weeks _____day Labor length hrs: _____
Anesthesia: _____Preterm labor: Yes No Delivery site: Vaginal / C-Section Gender: M / F
Complications: Yes No

__Family Medical History__: Breast cancer Ovarian cancer Uterine cancer Colon cancer Diabetes hypertension

__Social History:__ Smoker: Yes No Circle one: Cigarettes - Tobacco - E-Cigarettes/Vapes
Smoking - how much:_____ Tobacco-years of use: _____

__Surgical History__: (Circle all that apply)
Abdominoplasty Appendectomy Bilateral Mastectomy Breast Biopsy Breast Implants Breast Surgery Caesarean Section Cholecystectomy Colonoscopy
Colposcopy Dilation and Curettage Ectopic Preg. Endometrial Ablation
Endometrial Bx Sigmoidoscopy Hernia Repair Hysteroscopy Laparoscopy
Laparotomy LEEP Mastectomy Myomectomy Oophorectomy
Orthopedic Sx Ovarian Cyst Partial Hysterectomy Sinus Surgery Thyroid Surgery

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Tonsillectomy Adenoids Tonsillectomy Total Colectomy Total Hyst
Tubal Ligation OtherImplant

Past Medical History: (Circle all that applies to your medical history)

Acid Reflux (GERD) ,Acne, Allergies, Anemia, Anesthesia Complications, Anxiety Disorder, Art (IVF or FET),Arthritis, Asthma,Autoimmune disease, Birth Defects, Blood Transfusion , Breast Cancer , Breast Problem, Cancer, Deep Vein Thrombosis, Depression, Derm Disorders, Diabetes, Eating Disorder, Eczema, Endometriosis, Fibromyalgia, GI Problems, Gestational Diabetes, Headaches, Heart Disease, Heart Problems, Hematologic disorders, Hepatitis/Liver Disease, High Cholesterol, History of STI, Hypertension, Infertility, Kidney Disease, Kidney/Bladder, Lung Disease, Neurologic/Epilepsy, Osteoporosis, Ovarian Cancer, Polycystic ovary syndrome, Polyps, Pre-Eclampsia, Psychiatric Illness, Pulmonary, TB,Asthma, Stroke, Thrombophilias Thyroid Problems, Trauma/Violence, Varicosities

Signature: _____ Date: _____

CONSENT TO TREAT

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at GLOW and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

PATIENT SIGNATURE: _____ DATE: _____

APPOINTMENT WAIT TIMES

Here at Glow, we want to thank you for choosing us for your OB/GYN needs. Each patient deserves and will be treated with exceptional care.

An OB/GYN practice can be challenging to keep scheduled appointment times on track. Emergencies can arise at any time which may require our doctors to spend more time with a patient, or leave the office to head to the hospital. This also applies to our sonographers schedule.

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We will do our best to keep our current appointment times on track but sometimes it is out of our hands. Please keep this in mind when scheduling your appointment time close to another appointment, lunch time or picking up kids.

When it comes time for you to need us unexpectedly, expect the same treatment.

If you need to reschedule your appointment due to this, there will be no cancel or rescheduling fees. We will do our best to reschedule you and try to see you as soon as possible.

PATIENT SIGNATURE: _____ DATE: _____

PHI / Protected health information

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

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May we phone, email, or send you a text to confirm your appointments? Yes No

Phone/Email/Number to text: _____

May we leave a message on your answering machine at home, work or cell phone? Yes No

Number to leave a message: _____

May we discuss your medical condition with any member of your family? Yes No

If yes, please name the members allowed:

Name	Relationship to patient	Phone
Name	Relationship to patient	Phone
Name	Relationship to patient	Phone

I understand it is my responsibility to update GLOW, in writing, if any of this information changes.

By typing and dating your name in this box, you are electronically signing this application. You understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Patient : _____ _____

(Print and sign name) (Date)

Financial Policy

It is the philosophy of GLOW that all patients receive the best possible care and service.

Therefore, your complete understanding of our financial policy as it relates to your financial obligation is an essential part of our philosophy. Please read this thoroughly.

Many changes have taken place in the health insurance industry in recent years. Services once covered in full are now partially covered, covered only under certain circumstances, or in some cases not covered at all. It is your responsibility to know your plan benefits, please check with your insurance company regarding possible coverage exclusions.

Payment for all services provided by our practice is due in full at the time the services are rendered. Exclusions to this policy are those patients with insurance. Payment plans are available to patients who demonstrate a financial hardship. For further information, please contact the Billing Department at 972.722.2526.

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If you are a member of a healthcare organization that GLOW participates with, we will file your visit with this organization and your copayment is collected at the time you arrive for your appointment. If GLOW does not have a contractual agreement with your insurance carrier, we will bill available insurance carriers as a courtesy to you if an insurance card is provided to us at the time of service. You will be billed in full for any services that your health plan deems to be a non- covered service or any balance due after we have received payment from your insurance carrier. All patient balances are payable upon receipt of the statement.

It is our policy that any patient at the age of eighteen years or older will be financially responsible for all charges incurred. For any patient under the age of eighteen, the parent who accompanies the minor for their visit will be financially responsible for all charges incurred.

GLOW accepts Cash, Personal Checks, Money Orders, ATM Debit cards, MasterCard and Visa for services rendered. A $35 Returned Check Fee will be assessed to the account for every check returned to GLOW for insufficient funds. Refunds will be issued to guarantors. If the guarantor has an outstanding balance on another account, a refund will not be issued and the credit will be transferred to the account with the outstanding patient balance.

GLOW reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. A fee will be assessed to all accounts sent to a collection agency.

In the event you are unable to make your scheduled appointment, please cancel at least 24 hours prior to the appointment. GLOW reserves the right to bill our standard office visit fee for non- compliance to this policy.

The staff of GLOW believes that open and honest communication is imperative for you to receive the best care. If you have any questions about your financial obligation or health care needs, please feel free to discuss them with one of our staff members.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I have had an opportunity to review this office's Notice of Privacy Practices, which explains how my medical

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information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient (Print name): _____

Signature of Patient or Personal Representative: _____

Date: _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

GLOW
WELLNESS FOR LIFE

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Advanced Practice Nurse Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical (may indicate specialty) care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

Check one:

[ ] I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

[ ] I have read the above and declined the services of an advanced practice nurse for my health care needs.

_____ _____

Patient: Date:

_____

Signature:

****

Office use only:

[ ] Scanned in chart

[ ] Added note in Alert

info@glowbgyn.com www.glowbgyn.com

Follow us at: Instagram: glowbgyn Facebook: @glowbgyn Hashtag: #timetoGLOW

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GLOW-NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of another specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, and licensing or credentialing activities.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization. See PHI Form.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena
- Pertains to a victim of crime and you are incapacitated
- Pertains to a person who has died under circumstances that may be related to criminal conduct
- Is about a victim of crime and we are unable to obtain the person's agreement
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care. See PHI Form

Receiving Confidential Communications by Alternative Means

We may telephone you and leave a message about upcoming appointments, billing matters, or negative laboratory reports. You must advise the person listed below specifically if you do not want telephone messages of the above nature left for any particular reason. You may request that we send communications of protected health information by alternative means or to an alternative location. Such requests must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes

- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. 25.00

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice
- Is not part of the Designated Record Set
- Is not available for inspection because of an appropriate denial
- If the information is accurate and complete

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Sign-in Sheets and Announcing of Patients in Waiting Area

We provide a sign-in sheet for patients who have arrived at the office for their appointments. The signing-in provides a tool for the receptionists to confirm the presence of a scheduled individual as well as to provide a reference for future use. The sign-in sheet does not refer to any health information that could be associated with the patient.

A member of the clinical staff may enter the waiting room and call a patient by name when it is her time to see a provider. No information except the patient's name shall be used in the waiting area.

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Appointment Reminders, Treatment Alternatives, and Other Health-Related Benefits

We may contact you by telephone, mail, or both, to provide appointment reminders, information about treatment alternatives, or other healthrelated benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

GLOW
PRIVACY OFFICIAL
901 Rockwall Parkway
Rockwall, Texas 75032

This notice is effective on the following date: 01/01/2018 We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Patient: _____ Date: _____

OBSTETRICAL Financial Information

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Thank you for choosing GLOW for your pregnancy and delivery needs. In an effort to keep your healthcare costs to a minimum, we have adopted the following policies. Your understanding of these policies is important. Please review this document and contact our billing office with any questions you may have.

Dr. Theresa M. Conyac currently delivers at Baylor Scott & White Medical Center - Lake Pointe 6800 Scenic Dr, Rowlett, TX 75088 (972) 412-2273

*****Labs and ultrasounds are not considered to be part of the global fee and are billed separately at time of service. Depending on your insurance coverage, you may be responsible for a portion of these charges.** Initials _____

Patient Portion and OB Payment Plan:
After your initial visit, the billing staff will contact your insurance company to obtain benefits for pregnancy and verify any precertification of services required. Some insurance requires the patient to contact them for prenatal registration. If your insurance requires this, we will advise you to do so. Initials _____

OB Payment Plan:
When calling for pregnancy benefits, your insurance will advise us of your portion of the global fee. This is called your coinsurance. We are authorized by your insurance to collect this portion prior to delivery . **Our policy is that the amount due be collected by the fifth month of pregnancy.** We will create an OB Payment Plan that will be available by your second OB visit. The plan breaks down all the information that we received from your insurance as well as a payment arrangement for your portion. We offer these options in regard to payment:

- Payment in full (due at your third OB visit)
- Monthly payments at time of visit, up to fifth month
- Or any payment plan approved by management

Please remember that you may have a deductible that will have to be met. If this is the case, you may have additional charges that will be your responsibility. OB Payment owed is due by your fifth month, for patients with or without insurance.** Initials _____

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Co pays: Most insurances do not charge a copay per visit AFTER your initial visit. They do, however, charge copays for any testing or visit outside of the "Routine Prenatal Care". Specialized testing, such as non-stress testing, will require copays. Copays are due at time of service. Initials_____

HRA/HAS/Flex Spending: Higher deductible plans (HRA, HSA, and FLEX) encourage patients to share more responsibility for how their health care dollars are spent. This means that you will have a larger portion of your health care costs to pay. Plans vary from insurance to insurance making it almost impossible to track all plans. Due to this, GLOW requires the global fee to be paid by the fifth month of pregnancy, as with traditional plans. Initials_____

Changes in Insurance: Should you have a change in insurance during your pregnancy, please contact the billing department as soon as you have all of the new information. We will call and get benefits, meaning your payment plan may change. We will notify you of all the new benefits. Initials _____

A note about benefits Please keep in mind that although your insurance quotes benefits in regard to pregnancy, there is no guarantee of payment. Insurance considers many factors when claims are being adjudicated or processed. Any questions in regards to an insurance payment must be directed to your insurance company. Initials_____

Self Pay Patients: 500.00 is due at your first visit. We require that the remainder estimated amount be paid in 3 monthly payments or in full by your **fifth month of pregnancy**. If your balance is not paid in full by your fifth month of pregnancy, we have the right to terminate the doctor/patient relationship.
The fee for **uncomplicated** pregnancy, labor, delivery and postpartum care is 4250.00. Initials_____

Leaving the Practice: Should it be necessary for you to transfer care during your pregnancy, Theresa M. Conyac, MD will bill your insurance for the portion of the global fee. Initials_____

Tubal Ligation (sterilization) at Delivery: Sterilization procedures are an additional charge. Should you decide to proceed with sterilization, the billing department will contact your insurance in regard to benefits. You will be responsible for any co-insurance amounts prior to your delivery. The billing office will contact you once benefits are received. Initials_____

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As always, if you have any questions regarding this policy, please do not hesitate to contact our billing department, at 972.722.2526. We are more than happy to assist you.

Patient: _____ Date: _____

Authorization for Use or Disclosure of Patient Photographic and/or Video Images

Purpose:

The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*.

Facebook,Instagram, GLOW website,etc.

Revocability:

I understand that I may revoke this authorization at any time but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization will not expire. You must provide a statement in writing to cancel this agreement.

No Treatment Conditions:

I understand that the practice cannot condition and treat me whether or not I sign this authorization.

I authorize the use and disclosure of my name (and childrens), photographic/video images, and/or testimonial for marketing purposes by Theresa M. Conyac, MD and/or GLOW. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

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Facebook,Instagram, GLOW website,etc.

Approve ( ) ***Deny ( )***

Print Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Date: _____

I understand that Theresa M Conyac and/or any other physician or healthcare provider working for Theresa M Conyac are doing business as Theresa M Conyac, MD PLLC DBA GLOW.

They are accepting me as:

[ ] a private-pay (cash pay) patient for the period of my delivery (antepartum, delivery and postpartum only), a total of 10 months.

[ ] according to my health insurance contract I am enrolled in.

I understand I will be responsible for paying any services I receive through Theresa M Conyac, MD PLLC DBA GLOW.

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If you lose your current insurance coverage, it is up to the patient to contact our office to see if we are a network provider and update the information.

The physician or other healthcare providers above will **NOT** file a claim to Medicare/Medicaid for services provided for me, and Medicaid will **NOT** reimburse me for these services.

We are **NOT** a medicare/provider.

_____	_____	_____
Print Name	Sign Name	Date