Jose F. De Leon M.D., P.A.

Dallas Office: 214-879-3505 1330 Prudential Drive Ste. #100 Dallas, TX 75235
dallasoffice@doctordeleon.com
Irving Office: 214-492-0357 3501 N MacArthur Blvd. #310 Irving, TX 75062
irvingoffice@doctordeleon.com

Jose F. De Leon MD, Phuong Nguyen-Luu MD, Ernest Tako MD, Yolanda Escalante FNP-C

Welcome! We appreciate your selection of our office to service your obstetric and gynecologic needs. Our goal is to provide the best possible care to you, our patient. We have enclosed forms for you to fill out and bring to your initial visit including your:

· Photo ID

· Insurance card

· List of current medications

We understand that emergencies occur. We ask that you call to cancel or reschedule your appointment as soon as possible (preferably more than 24 hours in advance). This allows us to fill your appointment time with another patient needing care. Please be advised that 3 or more no shows or cancellations, with less than 24 hour notice, may result in cancellation fees of $25 or being released from the practice. **Please arrive 15 minutes prior to your appointment time**. Although we have no control over unexpected emergencies that may arise, we make every effort to see everyone on time. We will always take whatever time is necessary to provide you with the best care available. **If you are more than 15 minutes late to your appointment, you may need to be rescheduled** as it disrupts other patients' appointments.

As a courtesy, we will bill your insurance carrier for you. Any co-payments or deductibles must be paid at the time of services. We accept cash, checks and all major credit cards. Please contact your insurance carrier before your appointment to find out about your benefits, co-payments and deductibles.

We are eager to serve you. If you have any questions, phone calls are answered between the hours of 8:00 am -4:30 pm on Tuesdays through Thursdays and Mondays & Fridays 8:00am - 12:15 pm. You may always feel free to leave a detailed message and we will respond as soon as possible.

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Authorization to Release Information

Patient Name: _____ Date of Birth: _____
Previous Name: _____ Telephone Number: _____

I. My Authorization:

You may disclose the following health care information (check one):

- ☐ The most recent records from the last (2) years
- ☐ Health information from _____
- ☐ Specific _____

YOU MAY **RELEASE** HEALTH CARE INFORMATION TO:

- ☐ **Self** (please provide current address below). ****Fees may apply**.
- ☐ Facility/Doctor's Name:
  _____A
  ddress:_____City:_____State:_____Zip:_____
  Telephone Number:_____
  Fax:_____

II. My Rights

SENSITIVE INFORMATION: I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus), other sexually transmitted diseases, drugs and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the office and its staff from all legal responsibility of liability that may arise from the release of this information. At any time I may revoke this consent, except when the action has been taken.

- ☐ ***Please check here if you DO NOT want any of the above-mentioned information released. (**Checking this box may limit the amount of records that will be sent.)***

DISCLOSURE: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

REVOCATION: I may revoke this authorization in writing by writing a letter to my Health Care Provider at Jose F. De Leon M.D. PA.. If I do, it would not affect any actions already taken by Dr. De Leon and group based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient (*or legally authorized individual signature)*: _____
Printed Name: _____ Relationship: _____
Date: _____

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Dear Patient,

I always strive to provide the best medical care for my patients. Your visits with me often encompass various tests. For patients without insurance, I am able to bill you directly for those tests. However, for patients with managed care insurance, the insurance company requires the use of an outside lab. The most common of these labs are LabCorp, Quest Diagnostics, Propath, GTI and MDL.

Your lab work is sent to one of the designated labs, the lab bills your insurance, and any portion of the lab that is your responsibility is billed to you by the lab. I do not have any control over the billing by the lab. My medical staff and I make every effort to correctly code the lab requisition forms, and we are almost always without error in doing so.

If you experience a difficulty with your lab bill, please contact the lab directly. Labs have been known to tell you "your physician did not code the lab correctly," that is not a correct statement. What they usually mean is that your insurance did not pay for the test because it was a non-covered expense.

Why would an expense not be covered? Your employer has chosen a plan (or plans) that had a menu of benefits. Some plans cover well woman's (annual preventative exams), some cover well woman's exams with a limit, and some do not cover the well woman's visit at all. Some lab tests are included in your insurance company's preventative coverage and some are not. I determine which labs are needed based upon my judgment of medical necessity for you. These tests may not be covered by your insurance plan.
I regret that I cannot intervene in the lab billing issues and that I cannot provide pricing information for these tests, or control what is or is not covered. What I can do is continue to provide you with excellent medical care and continuing interest in your health and well-being.

Sincerely,

Jose F. De Leon, M.D.

Patient Signature: _____ Date: _____

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Adult/Minor Hippa Consent

Consent to speak to: _____ Relationship: _____

Contact Number: _____

Notice of Privacy Practices

Notice of Privacy Practices We will not disclose your records to others unless you direct us to do so or the law authorizes or compels us to do us. Our more detailed Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information ***(available upon request).***

Authorization to be treated and Authorization to Bill

Authorization to be treated / Authorization to Bill I understand that I am financially responsible for all charges not covered by my authorization or insurance. Verification of coverage and any pre-authorization requests are not a guarantee of payment. I acknowledge that my insurance carrier may feel the exams and/or treatment recommended are not medically necessary, or they may disagree with the final diagnosis, or I may not have obtained permission from my primary care provider for the services provided. If my insurance carrier or primary care provider fails to authorize payment for services rendered I will be financially responsible for payment in full. I authorize Kitsap OBGYN, PLLC to release any information acquired in the course of my examination or treatment to my insurance company.

Patient or Legally Authorized Signature: _____

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PATIENT MEDICAL HISTORY INTAKE FORM

Patient Name: _____ **DOB:** _____

How were you referred to our office?_____

Chief complaint (reason for your visit):
_____

Please list **any medical problems** that you have been diagnosed with:

_____

Please list your current medications that you are taking:

_____

Who is your **primary care provider**?

_____

Preferred **pharmacy name & number**:_____

Allergies: _____
List the reactions to these allergies?
_____

GYN History:
First day of your last menstrual cycle: _____
Do you have menstrual cycles every 28 to 30 days? _____
Does it take longer than 35 days to have a cycle? _____
Is the time between your cycles ever shorter than 19 days? _____
Character of your cycle check all that apply:
Heavy_____ Clots _____ Irregular _____ Painful _____
Skipping Periods _____ PMS _____
Vulvar/Vaginal problems discharge, odor, itching, rash/lesions, pain, other:
_____
Pelvic Pain _____ Pain with sex _____ Bleeding with sex _____

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Are you sexually active? _____ With men? _____ Women? _____ Both?_____ Would you like STD testing?_____Date of last pap smear: _____ Abnormal results? _____ Treatment: _____
What type of birth control do you use? _____
Menopause issues: hot flashes/night sweats _____
Postmenopausal bleeding _____ Vaginal dryness _____
Any breast lumps? _____ Other Concerns _____
Have you ever had a mammogram? _____ When? _____

Urinary Problems: pain, frequency/urgency, incontinence, blood in urine,
_____
Gastrointestinal Problems: diarrhea/constipation, bloody stools, bloating, hemorrhoids
_____
Last Colonoscopy _____ Date of DEXA/bone density scan _____

OB History:
Are you pregnant? _____ **Are you trying to conceive?** _____
# of pregnancies: _____ # of babies have delivered _____ full-term _____
pre-term (less than 37wks)_____# of miscarriages_____
# of abortions_____ # of ectopic _____Death or infant or child _____
# of c-sections_____
Do you have a history of any sexually transmitted infections/disease(s)?_____ If so, what type: _____

Please list all of your past surgeries & include the month and year:
_____

Family History: The following questions pertain to your family history.
Is your mother alive? _____ Yes _____ No
Does your mom have any of the following illnesses? Select all that apply
_____ Diabetes _____ High blood pressure _____ Low blood pressure
_____ High cholesterol _____ Heart disease _____ Stroke _____ Cancer
_____ Mental illness _____ Other
Is your father alive? _____ Yes _____ No
Does your father have any of the following illnesses? Select all that apply
_____ Diabetes _____ High blood pressure _____ Low blood pressure

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_____ High cholesterol _____ Heart disease _____ Stroke _____ Cancer
_____ Mental illness _____ Other, please list _____

How many brothers do you have? _____ What medical problems do they have?
_____

How many sisters do you have? _____ What medical problems do they have?
_____

How many boys do you have? _____ List any medical problems they have
_____

How many girls do you have? _____ List any medical problems they have
_____

Do you currently smoke or use any tobacco products? _____

Are you experiencing any of the symptoms below (circle if applies):

Fever
Chills
Fatigue
Sudden weight gain
Sudden weight loss
Nausea
Sleep disorder
Depression

Patient Signature: _____ Date: _____

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PATIENT DEMOGRAPHICS

Today's Date: _____

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Phone Number: _____

Email Address: _____ *(necessary for Healow App)*

Social Security Number: _____

Preferred method of contact:

- ☐ Web Message
- ☐ Text
- ☐ Email
- ☐ Phone call, may we leave a message? _____

Emergency Contact:

Name: _____
Relationship: _____
Phone Number: _____

Marital status(circle): married single divorced

Home Address: _____

City: _____ State: _____ Zip Code: _____

☐ Check here if mailing address is different than above & add below:

Mailing Address: _____City: _____

State: _____ Zip Code: _____

INSURANCE INFORMATION

Subscriber Name: _____ Date of Birth: _____

Relationship to patient: _____ Phone Number: _____

Insurance Carrier:_____ Phone Number: _____

Insurance Claims Mailing Address: _____

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City _____ State: _____ Zip Code: _____

Insurance ID: _____ Group Number: _____

I understand that the office staff will obtain an estimated summary of my insurance benefits, however there is no guarantee of payment. I understand that all estimated co-payments, deductibles, and other fees will be collected upfront. I will be held responsible for any amount(s) that are not covered by my insurance. Please refer to the *Authorization to be treated and Authorization to Bill* section.
Patients with balances over $100 must make payment arrangements prior to further appointments being made. If a scheduled surgery is not canceled at least 7 days in advance a fee of $50 will be applied to your account balance.

Patient Signature: _____

or Responsible Party if Patient is a Minor: _____

Print: _____ Date: _____