Welcome to Lake Pointe Women's Centre

Thank you for choosing Lake Pointe Women's Centre to assist in your medical care. It is our goal to meet the needs of our patients. We hope to leave you informed and more than willing to return should the need arise.

Lake Pointe Women's Centre has two locations, and the most efficient way to contact us is to call that location. These numbers are answered twenty-four hours a day.

6900 Scenic Dr. Ste. 101 Rowlett, TX. 75088 972-475-7555	763 E Hwy 80, Ste. 130 Forney, TX 75126 972-564-0050

Co-Pays and Deductibles:
These are due and payable upon check-in. You may also be responsible for any deductible required to be satisfied by your plan.

Insurance Information:
This information ***must*** be current. If you have recently had a change of insurance and have not yet received your ID card, you must present us with all the necessary information needed to submit the claim. It is not the responsibility of our office to call the insurance carrier for this information. Should you present us without the necessary information, you may be seen as a "Self Pay" patient or reschedule.

Prescription Refills:
Refills will not be authorized for patients that have not been seen in our office in excess of one year. Please make a conscious effort to keep track of your medication supply. Do not allow yourself to run out of medication before calling for a refill. Certain medications require close monitoring and may not be refilled unless you see your provider.

Medical Records Request:
We require at least a 24 hr notice. There will be a $25 fee for medical records. Should you request that we send your records to a physician other than a referring physician, we must have a signed release from the patient. There is no charge for sending records directly to another physician.

Appointment Schedule:
Appointments are scheduled at intervals to accommodate time with our patients. Should for some reason you need to reschedule an appointment, please provide at least 24 hr. notice or you may be subject to a $35.00 fee. This fee will not be billed to your insurance carrier. It is will be your responsibility. This is not only courteous, but it allows time for our office to fill the space.

Calls To The Office:
You may contact the office between 8:30am - 5:00pm Mon - Fri. Calls are directed to medical assistants or nurses. All calls are returned within 24hrs, unless the call is an emergency. If the call is an emergency, relate this to the receptionist so your call may be properly handled. Please have your pharmacy phone number available when calling in case medication is necessary.

What is a Nurse Practitioner?
A Nurse Practitioner is a registered nurse that has received specialized training (often at a graduate level) in diagnosing and treating illnesses and providing health care maintenance. Nurse Practitioners do not perform surgery or deliver babies. They consult with a physician for problems not covered under their approved protocols or when questions arise. You always have the option to see the physician.

Again, Welcome
Lake Pointe Women's Centre Physicians & Staff

Lake Pointe Women's Centre

PATIENT INFORMATION:
Please print clearly and fill out completely: Primary Care Physician__________________ Referred By___________________________

Name____
First Middle Last
Address____
Street Apt City State Zip
Primary Phone (___)________________(**Please circle)** Home/Work/Cell Secondary phone(___)_______________(**Please circle)** Home/Work/Cell

Alternate Phone (___)_______________**(Please circle)** Home/Work/Cell **E-Mail address:** ____

Date of Birth____/____/_____Age_____ Social Security #_______________________Driver License_______________State___

Name of Employer____Phone #(___)_______________

Address____City______________________State_____Zip_________

Martial Status______ Spouse/Significant Other's Name____Phone Number(___)______________

Primary Insurance Information

Name of Insurance____

Insurance Address for Claims____City_____________State_____Zip___________

Name of Insured____ Relationship to Patient___________________________________

Insured's Information:

Date of Birth___/____/____ Insured's Social Security #________________Member #___________________Group #________________________

Insured's Employer____Phone #(___)________________

Insured's Employer Address____City______________________State______Zip_________

Secondary Insurance Information

Name of Insurance____

Insurance Address for Claims____City_____________State_____Zip___________

Name of Insured____ Relationship to Patient___________________________________

Insured's Information:

Date of Birth___/____/____ Insured's Social Security #________________Member #___________________Group #________________________

Insured's Employer____Phone #(___)________________

Insured's Employer Address____City______________________State______Zip_________

Nearest Friend or Relative Not Living With You (In case of an emergency)

Name____Relationship to Patient_____________________

Address____City______________________State_______Zip_____________

Home Phone (___)_______________Business Phone(___)_______________________Pager(___)____________________Mobile(___)_______________

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical to which I am entitled, including Medicare, and other government sponsored programs, private insurance and any other health plan to Lake Pointe Women's Centre. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signature____Date_____/_____/_____Account #_____________________

NOTICE OF PRIVACY PRACTICES
LAKE POINTE WOMEN'S CENTRE

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

Effective Date: APRIL 14, 2003
This Notice was revised on AUGUST 1, 2013.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Louis R Turano
Mailing Address: 6900 Scenic Dr., Suite 101, Rowlett, TX 75088
Telephone: 972-475-7555
Fax: 972-412-0935
Email: lrturano@lpwc.net

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Lake Pointe Women's Centre

Obstetrics and Gynecology

6900 Scenic Drive
Suite 101
Rowlett, Texas 75088
972-475-7555

763 E Hwy 80
Suite 130
Forney, TX 75126
972-564-0050

Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the LPWC Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by LPWC and how I may obtain access to and control this information.

_____________________________________ _________________
Signature of Patient or Personal Representative Date

_____________________________________ _________________
Print Name of Patient or Personal Representative Date

____
Description of Personal Representatives Authority

Updated 1/25/2012

Lake Pointe Women's Centre

Please list who you want to have access to your pertinent medical information.
(i.e.: family member, spouse, significant other) **If you are under the age of 18 your parent / guardian has the right to ALL medical information without your consent.**

______________________________	______________________
Name	Relationship to Patient
______________________________	______________________
Name	Relationship to patient
______________________________	______________________
Name	Relationship to patient

( ) Do not allow access to my medical information to anyone.

May we leave a message on an answering machine?

Home	Yes	No
Cell	Yes	No
Work	Yes	No

What is the best way for our office to contact **YOU** for test results or appointment reminders?

E-mail:_______________________________

________________________	home / work / cell
Primary Phone Number	(please circle)
________________________	home / work / cell
Secondary Phone Number	(please circle)
________________________	home / work / cell
Alternate Phone Number	(please circle)

Signature____________________________Date_____________

Lake Pointe Women's Centre

Dear Patient:

I am informing you in advance that a service may not be covered because your insurance company may determine that it is not "reasonable and necessary". Although this wording implies that such services are not medically necessary and/or routine, I must emphasize that, in my professional judgment, these services are needed in order to render high quality care to you.

The following are some guidelines that may result in denial of service(s).

Expenses are not payable due to Employer Plan Provisions:

- Plan maximum are not covered under plan provisions
- Not eligible for coverage on the date(s) services rendered
- Routine physical or other examination or other preventative service
- Payment reflects carrier's determination of the usual and customary charge for this service
- Expenses are not payable due to other benefit limitations on this plan and are the responsibility of the insured
- Routine services are not covered
- Pre-existing conditions may not be covered
- Other____

By signing this statement, you are agreeing to pay for service(s) rendered, even if your insurance carrier determines that, according to its guidelines, the services are not "reasonable and necessary".

____
Print Patient Name

_______________________________________ ____________________
Patient's Signature Date

_______________________________________ ____________________
Guardian's Signature (if patient is a minor) Date

_______________________________________ ____________________
Witness's Signature Date

Updated 1/25/2012

Lake Pointe Women's Centre
Obstetrics and Gynecology

6900 Scenic Drive
Suite 101
Rowlett, Texas 75088
972-475-7555

763 E Hwy 80
Suite 130
Forney, TX 75126
972-564-0050

General Consent for Medical Treatment

I_________________________________, authorize and direct the practitioners of Lake Pointe Womens Centre, to render medical care as determined necessary at the time of service.

________________________________ ________________
Patient's Signature Date

________________________________ _________________
Witness' Signature Date

If patient is a minor or unable to sign:

_________________________________ _________________
Name of Person Giving Consent Relationship

_________________________________ __________________
Signature Date

_________________________________ __________________
Witness's Signature Date

Medical History

Name:________________________________ Age______ DOB:___/___/____ Today's Date___/___/___
Current Occupation____

Gyn History

What was the date of your last pap smear_________
Have you been diagnosed with an abnormal pap smear? [ ] No [ ]Yes
If yes, when ____________________________________
Have you had or ever been advised you need a mammogram [ ] No [ ] Yes
Date of last mammogram___________
Are you currently sexually active? [ ] No [ ] Yes
What is your current method of contraception_________
Are your immunizations current? [ ] No [ ] Yes

Menstrual History

Age at onset of periods
Regular Cycles [ ] No [ ] Yes
Cycle length days (start to start)
Duration of flow days
Pain or cramps [ ] No [ ] Yes
Flow [ ]Light [ ] Moderate [ ] Heavy
First day of last menstrual period

Have you been diagnosed and/or treated for: [ ] Herpes [ ] Gonorrhea [ ] Chlamydia [ ] HIV [ ] Vaginal infections [ ] Pelvic inflammatory disease
Do you: Smoke [ ] No [ ] Yes [ ] Quit If yes, number of cigarettes a day______, how many years______
If you have quit, what year___________
Alcohol [ ] No [ ] Yes If yes, amount consumed weekly_________________________________
Illicit drug use; (i.e. marijuana, cocaine, etc.)____
Current Medications:____
Drug Allergies:____

Review of Systems

Do you have or have you had any of the following:

- [ ] Anemia
- [ ] Asthma/lung disease
- [ ] Autoimune disorder
- [ ] Bleeding disorder
- [ ] Blood clots in legs
- [ ] Blood transfusion
- [ ] Heart disease/Murmur
- [ ] Hepatitis/liver disease
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Incest/Rape
- [ ] Jaundice
- [ ] Migraine headaches
- [ ] Painful intercourse
- [ ] Sexual dysfunction
- [ ] Thyroid disorder
- [ ] Varicose veins

Pregnancy/Delivery History

Yr. Del	Sex	Weight	Hrs of Labor	Hospital	Complications

Surgical/Procedure History

Year	Procedure/Surgery Performed

Urological History

Have you had any history of bladder or kidney infection? [ ] No [ ] Yes
Do you lose urine with coughing, sneezing or exercise? [ ] No [ ] Yes
Have you had surgery for urinary difficulties? [ ] No [ ] Yes
Do you have a history of kidney stones or blood in the urine? [ ] No [ ] Yes

Family History

Family Membe	Age	Living	If deceased, cause of death
Mother			
Father			
Brother(s)			
Sister(s)			

Has any of your family had: (list relative)
Diabetes
High Blood Pressure
Breast Cancer
Ovarian Cancer
Endometriosis
Other hereditary disease

Is there a history of bleeding or easy bruising in you or your family? [ ] No [ ] Yes

Lake Pointe Women's Centre

Obstetrics and Gynecology

DISCLOSURE

The Lake Pointe Women's Centre physician you are seeing may have a financial interest in one or more of the following facilities:

Rockwall Surgery Center
825 W Yellowjacket Lane
Rockwall, TX 75087
(972) 772-6166

The facility and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you.

It is possible that out-of-network providers may provide all or part of the covered services at these facilities. You may contact your insurance carrier for more information.

Your physician may also have a financial interest in the following entity:

RXpress
550 Hemphill Street
Fort Worth, TX 76104
(866) 405-0432

RXpress is a compounding pharmacy that dispenses custom designed prescription medication for the treatment of hormonal imbalance and provides direct to the patient delivery. The financial interest in this entity assures that the patient receives only the highest quality compounded medications.

Should you have any questions or concerns regarding this notice, please ask your physician or a member of his staff.

This verifies that I have read and understood the above statement.

Signature: ________________________________ Date: _________________