SAMUEL P. MARYNICK, M.D.,P.A.
3600 Gaston Avenue 506 Barnett Tower
Dallas, Texas 75246
Ph# 214-828-2444
Fax# 214-821-5015

Welcome to the office of Dr. Samuel P. Marynick, M.D.

The primary goal of this office is to provide high quality medical care. To help us achieve this goal the following information is given to our patients. Please read these few pages and feel free to ask any questions.

Dr. Marynick is an attending physician at Baylor University Medical Center, program director at the Texas Center for Reproductive Health, and a Fellow of the American College of Physicians, the American College of Endocrinology, and the College of Reproductive Biology. Board certified in internal medicine, endocrinology and metabolism, high complexity laboratory testing, andrology and embryology, Dr. Marynick's interests include all areas of endocrinology and metabolism with a significant portion of his practice devoted to male and female infertility evaluation and treatment, assisted reproduction technologies, neuroendocrinology, growth disorders, thyroid disorders and bone and mineral metabolism.

YOUR APPOINTMENT: **If you have seen a physician previously, it is your responsibility to bring to your appointment all previous tests, x-rays, and MRI films as well as medical records from your treating physician. Please bring the information package with you to your appointment. Do not mail it back to us. When you come to your appointment, please bring your current medications with you (in the containers) along with a list of the medications and be prepared to give up-to-date medical information.**

FEES: Our fees are standard for the practice of endocrinology. Locally and nationally there are endocrinologists whose fees are greater and lesser. The fee schedule is designed to cover the cost of an efficient office. Endocrinology testing is expensive. (Please see explanation of Immunoassay Testing.)

You are responsible for all of your charges in this office. Full payment is due at the time of service. We accept cash, check, Visa and MasterCard. Prompt payment allows for the control of cost. All patients must have a signed payment agreement on file prior to treatment.

OFFICE HOURS: Office hours are from 9:00 a.m. to 4:00 p.m.. The office is closed the noon hour for lunch. The office is also closed all day on Thursday. Telephones are answered from 9:00 a.m. to 12:00 p.m. and from 1:00 p.m. to 4:00 p.m. Appointments may be made by calling 214-828-2444 during office hours.

We confirm all appointments at least 48 hours in advance. Please call our office to confirm your scheduled appointment. Please schedule all appointments as soon as Dr. Marynick tells you when he would like for you to return. This will give you a better selection of available appointment times.

EMERGENCIES: Dr. Marynick generally takes his own calls. If you have an emergency and cannot reach the doctor, go to an emergency room, preferably Baylor Medical Center. They will contact the doctor "on call". If you have an emergency, please do not hesitate to call the doctor. **Please do not call after hours for matters that can be handled during regular office hours.**

TEST RESULTS AND PRESCRIPTIONS: If you have testing done in our office, Dr. Marynick will write a letter to you when all the test results have been returned from the laboratory. It can take 10 working days for the tests to be completed. Your letter will contain the results of your test, what they mean, and Dr. Marynick's recommendations. If applicable, the referring physician will be sent a copy of the letter. If the doctor wishes to start you on any medication, a prescription will be enclosed in the letter. He will also state when he wishes to see you back for follow-up. Dr. Marynick and the Texas Board of Medical Examiners will require a regular follow-up visit to continue prescribing medication. Please do not call for test results unless it has been 10 days since your visit, as the office personnel are not authorized to give out test results.

ENDOCRINOLOGY TESTING IMMUNOASSAYS: Many patients are surprised by the costs of the tests that are required to evaluate endocrine diseases or problems. The cost of these tests are great compared to most general medical laboratory tests, because of the materials necessary to measure the small quantities of hormones that are found in the body. Most hormones are measured in nannogram or picogram quantities. These levels are 1/10,000 to 1/1,000,000 the concentration of some of the chemicals commonly measured in the body such as calcium or cholesterol that are found in milligram quantities.

To measure minute quantities of hormone requires a process known as immunoassay. To perform an immunoassay requires a standard and a specific antibody to the standard. Most of the immunoassays we perform require several steps to complete and have components that are generally very costly.

WHEN YOU CALL OUR OFFICE

Before you call the doctor's office, take a few minutes to get ready.

Make a list of your symptoms:
- What is bothering you? Be specific.
- How long have you had the problem?
- What have you tried to make it better?
- Be able to tell the nurse or doctor all medicines you are currently taking.

Write down any questions you may have for the doctor or his staff.

A member of our staff will return your call as soon as possible.

If you feel you will need to see the doctor, please call as early in the day as possible.

Most prescriptions can be refilled directly through your pharmacy. Even if your bottle says "0" refills, go ahead and call the pharmacy to request a refill. They will in turn fax us and obtain authorization from us for additional refills. Do not wait until you are almost out of medicines before you call the pharmacy for refills. Sometimes we have to do some research or we may have trouble communicating with your pharmacy. Please have our fax number, 241-821-5015, ready when you call for a prescription, along with the correct name and spelling of the medication you are requesting.

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PATIENT DATA

Name:____Date of Birth:_____________
First M.I. Last

Address:____
Street City State Zip

Home Phone#:__________________________Cell Phone#:__________________________

Email:____

Employer:_______________________________Work Phone#:________________________

Occupation:______________________________Social Security#:_____________________

Referred By:____

EMERGENCY DATA

Closest Relative:_________________________________Phone#:______________________

Close Friend:____________________________________Phone#:_____________________

INSURANCE DATA

Primary Insurance Co.____

Subscriber Name____________________________________DOB_____________________

Subscriber I.D.______________________________________Group#____________________

Claims Address____

Phone#____________________

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize this office to release all information to insurance companies.

Signature:____Date:________________________

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MEDICAL HISTORY

NAME: ____________________ AGE: _______ DATE OF BIRTH: ____________________
ALLERGIES: ____________________
MEDICATIONS: ____________________
____
____
SURGERIES: ____________________
____
____________________ BLOOD TRANSFUSION? ____________________

OCCUPATION: ____________________ TOBACCO: ________ ALCOHOL: ________ EXERCISE: ____________________

HAVE YOU EVER HAD: (YES OR NO)

GERMAN MEASLES:	_____	STOMACH TROUBLE:	_____	KIDNEY INFECTION:	_____	LUNG DISEASE:	_____
RHEUMATIC FEVER:	_____	RECTAL BLEEDING:	_____	BLADDER INFECTION:	_____	ASTHMA:	_____
LYMES DISEASE:	_____	ULCER:	_____	SWELLING:	_____	CHEST PAIN:	_____
DIABETES:	_____	ANEMIA:	_____	HIGH BP:	_____	THYROID PROBLEM:	_____
CANCER:	_____	JAUNDICE:	_____	STROKE:	_____	AUTOIMMUNE DISORDER:	_____

IF YES TO ANY, PLEASE EXPLAIN: ____________________

FAMILY HISTORY: Has any blood relative ever had the following? (Please list relationship, ie: mother, father, brother, sister, aunt, uncle, grandparent, etc.)

DIABETES: ____________________ KIDNEY PROBLEM: ____________________ CANCER: ____________________
STROKE: ____________________ OSTEOPOROSIS: ____________________ HIGH BP: ____________________
ENDOCRINE: ____________________ THYROID DISORDER: ____________________ HEART DISEASE: ____________________
DETAILS: ____________________
____

MENSTRUAL HISTORY:

AGE OF ONSET: _____ REGULAR: _____ IRREGULAR: _____ DURATION OF FLOW: _____ Light: ______ Medium: ______ Heavy: ______
NUMBER OF DAYS FROM ONSET OF ONE PERIOD TO THE NEXT: _____ PAIN OR CRAMPS: _____ DATE OF LAST PERIOD: _______
DATE OF LAST PAP SMEAR: _____________ HYSTERECTOMY: ______________ D & C: ______________ C-SECTION: ______________

NUMBER OF PREGNANCIES: (Include miscarriages) ______________

YEAR / INFANT WEIGHT / GENDER / HOURS OF LABOR / COMPLICATIONS

1. ____________________

2. ____________________

3. ____________________

4. ____________________

CONSENT TO DIAGNOSE AND TREAT:

By signing below I give Samuel P. Marynick, M.D., P.A. and associated personnel permission to treat me for my condition(s) by using tests, medication or other procedures that are deemed necessary for my evaluation and treatment. If I am the parent or legal representative of a minor that is a patient being seen by Samuel P. Marynick, M.D., P.A., I give my permission for Dr. Marynick and/or his personnel to evaluate and treat the minor patient for whom I am legally responsible.

____________________ ________ ____________________ ________
Signature of person giving permission Date Witness signature Date

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Privacy Questionnaire

Please list the family members or other persons whom we may inform about your general medical condition and your diagnosis:

____

____

Please list the family members or significant others whom we may inform about your medical condition ONLY IN AN EMERGENCY:

____

____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home**:

____

____

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information **if other than your home phone number:**

____

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? YES__________ NO__________

If you do not have voicemail, can a confidential message be left at your place of employment? YES__________ NO__________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Samuel P. Marynick, M.D. P.A. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for **Samuel P. Marynick, M.D., P.A.**

___________________________________	___________________________________
Name of Patient (Print or Type)	Signature of Patient

Date: ______________________________

___________________________________	___________________________________
Name of Patient Representative (Print or Type)	Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form.)

Date: ______________________________

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PAYMENT AGREEMENT

Thank you for choosing the office of Dr. Samuel P. Marynick as your healthcare provider. We are committed to providing the highest quality medical care.

I understand that full payment is due at the time of service. We accept cash, check, Visa and MasterCard. Prompt payment allows for the control of cost.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Our staff will make every effort to make the payment process as easy as possible.

If you have any questions, please contact us immediately.

____ ____________________
Signature of patient or responsible party | Date

____ ____________________
Driver's license number | Expiration date