

LESLIE P. STONE, M.D.

595 N. MAIN STREET, SUITE 2
ASHLAND, OR 97520

TELEPHONE: (541) 488-1116

OB/Prenatal Patient Agreement

In order to insure that I receive adequate prenatal care throughout my pregnancy

I, _____ agree to:

- | | Initial |
|--|---------|
| 1. Keep all scheduled appointments | _____ |
| 2. Reschedule any appointments that I cannot make at least 24 hours in advance of the originally scheduled appointment | _____ |
| 3. Attend one OB group meeting for each trimester | _____ |
| 4. Present my current insurance OMAP card at the time of each office visit | _____ |
| 5. Comply with any financial agreements arranged with Stone Medical P.C. | _____ |

I understand that failure to comply with this agreement may result in a dismissal of care. If care is terminated, I assume accountability for the health of my pregnancy and its outcome. I understand that it is not the responsibility of the doctor or the doctor's office staff to find another source for prenatal care in this case.

Patient Signature

Date

Print Patient's Name

Date of Birth
