Associates in Urogynecology

BLACK INK ONLY

PATIENT INFORMATION SHEET

PATIENT INFORMATION:		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Home Phone:	Cell Phone:	
E-Mail Address:		
Employer:	Occupation:	Work Phone:
Social Security Number:		
Primary Language:	Ethnic Origin:	Race:
EMERGENCY CONTACT INFORMATION:		
Name:	Relationship:	Phone:
PRIMARY INSURANCE:		
POLICY HOLDER		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:	Social Security Number:	
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	
SECONDARY INSURANCE:		
POLICY HOLDER		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:	Social Security Number:	
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	

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PATIENT INFORMATION SHEET

MEDICAL PROVIDER INFORMATION:			
Name:			
Primary Care Physician:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
Referring Physician:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Signature:_____

Date:_____

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TopLine MD Alliance

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Medication Name	Dosage	Frequency	Reason for Taking

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PATIENT QUESTIONNAIRE

Date of Appointment: _____

Last Name: _____ First Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Number of Pregnancies: _____ Number of Vaginal Births: _____ Number of C-Sections: _____

Weight of Largest Baby: _____ Form of Birth Control: _____ Date LMP: _____ Age at Menopause: _____

Do you smoke? ☐ yes ☐ no _____packs per day Do you drink alcohol? ☐ yes ☐ no _____drinks per day

Listed below are a series of questions regarding your bowel, bladder or pelvic symptoms, as well as your degree of discomfort, if any. Using the "key" - in the gray box - please place an **X** next to the appropriate number for each question below. While answering these questions, please consider your symptoms **over the last 3 months.**

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

1. Do you experience pressure in the lower abdomen? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

2. Do you experience heaviness or dullness in the pelvic area? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

4. Do you have to push on the vagina or rectum to complete a bowel movement? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

5. Do you experience a feeling of incomplete bladder emptying? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

6. Do you have to push up on a bulge in the vaginal area to start/complete urination? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

7. Do you feel you need to strain too hard to have a bowel movement? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

8. At the end of a bowel movement, do you feel you have not completely emptied your bowels? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

9. If your stool is well formed, do you lose stool beyond your control? ☐ yes ☐ no
   If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

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Name:_____

Date:_____

KEY:
1 - Not at All
2 - Somewhat
3 - Moderately
4 - Quite a Bit

10. If your stool is loose or liquid, do you lose stool beyond your control? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

11. Do you lose gas from the rectum beyond your control? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

12. Do you have pain when you pass your stool? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

14. Does a part of your bowel ever pass through your rectum and bulge outside, during, or after a bowel movement? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Do you usually experience frequent urination? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

16. Do you experience urine leakage associated with a strong sensation of needing to go to the bathroom? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

17. Do you experience urine leakage related to coughing, sneezing, or laughing? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

18. Do you experience small amounts of urine leakage (that is drops)? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

19. Do you experience difficulty emptying your bladder? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

20. Do you experience pain or discomfort in the lower abdomen or genital region? ☐ yes ☐ no
If yes, how much does it bother you? ☐ 1 ☐ 2 ☐ 3 ☐ 4

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QUALITY OF LIFE ASSESSMENT

Last Name:_____ First Name: _____

Age:_____ Date of Birth:_____ Height:_____ Weight:_____

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships, and feelings. Place an ***X*** in the response that best describes *how much* your activities, relationships or feelings have been affected **by your bladder, bowel or vaginal symptoms over the past 3 months.**

How do symptoms or conditions related to the following usually affect your...

Ability to do household chores (cooking, housecleaning, laundry)?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Ability to do physical activities such as walking, swimming, or other exercise?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Entertainment activities such as going to a movie or concert?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Ability to travel by car or bus for a distance greater than 30 minutes away from home?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Participating in social activities outside your home?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

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Name:_____

Date:_____

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QUALITY OF LIFE ASSESSMENT

Emotional Health (nervousness, depression, etc.)?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Feelings of frustration?

Bladder or urine	Bowel or rectum	Vagina or pelvis
☐ Not at all	☐ Not at all	☐ Not at all
☐ Somewhat	☐ Somewhat	☐ Somewhat
☐ Moderately	☐ Moderately	☐ Moderately
☐ Quite a bit	☐ Quite a bit	☐ Quite a bit

Associates in Urogynecology

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

( ) A female Gynecological Exam which may include a rectal exam and a pelvic exam

( ) Examination of external genitalia

( ) Other procedures as listed _____

This examination will be performed by any provider/nurse/medical assistant from Associates in Urogynecology, MD LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative, if under 18

X _____

Date _____

Associates in Urogynecology, MD, LLC
70 W. Gore St, Suite 201 Orlando FL 32806
Telephone (407) 286-6190 / Fax (866) 307-6193

Associates in Urogynecology

CONSENT TO TREATMENT:

Patient Name:_____ Date: _____

Date of Birth: _____

I, _____, hereby voluntarily consent to outpatient care at Associates in Urogynecology, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work, administration of medications, or other as prescribed by the physician or their assistants, including nurse practitioners and physician's assistants. I also consent to a medically indicated examination including but not limited to a pelvic exam. I authorize Associates in Urogynecology to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. I authorize the release of medical information about treatment here to my doctor or anyone designated by me. I understand that this consent form will be valid and remain in effect as long as I receive medical care at Associates in Urogynecology.

Signature of Patient: _____

If a minor, Signature of Relative or Guardian: _____

Name of Relative or Guardian: _____

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Associates in Urogynecology

Patient Acknowledgement of Provision of Notice of HIPAA Privacy Practices Policy

I, _____ acknowledge that Associates in Urogynecology has provided me with its Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

-OR-

Personal Representative name (Please Print): _____

Signature of Personal Representative: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

AIU tried to obtain written Acknowledgement by the individual noted above of receipt of our HIPAA Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other:

Staff Member Signature: _____ Date: _____

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AIU Associates in Urogynecology

CONTACT BY EMAIL, PHONE, OR TEXT:

I authorize Associates in Urogynecology to contact me by (PLEASE CHECK ALL THAT APPLY):

☐ E-mail ☐ Phone Call ☐ Satisfaction Surveys

My preferred method is (circle one): Email Phone

I understand that Associates in Urogynecology cannot control the security of this information once e-mailed (if outside of our Patient Portal) and cannot take full responsibility of any breach in security during the electronic submission of my information.

Signature of Patient: _____

RELEASE OF INFORMATION & CONFIDENTIALITY

I, _____, hereby authorize the following individuals access to ALL of my health care information from Associates in Urogynecology. I understand that if no individuals are listed below, no one but myself will have access to my health information from AIU.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient: _____

Associates in Urogynecology

Health Insurance Payment Agreement Financial Policy

I, _____, agree that it is my responsibility to pay my applicable fees for service, copayment, coinsurance, and/or deductible for every visit at Associates in Urogynecology, MD, LLC at the time of service.

If you have health insurance coverage we will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

I understand that if on a payment plan, the credit card on file will be charged according to the plan.

By signing below you confirm you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize temporary financial problems may affect timely payment of your account. If such problems arise, we urge you to contact us promptly for assistance in the management of your account.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient's Signature _____ Date_____

Associates in Urogynecology

CANCELLATION / NO SHOW POLICY

Thank you for trusting your care to Associates in Urogynecology. When you schedule an appointment with AIU we set aside enough time to provide you with the highest quality care. Should you need to reschedule or cancel an appointment, please call our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment. Our policy is below:

- Effective August 15, 2020, any established patient who fails to show or cancel/reschedule an appointment, and has not contacted our office with **at least 3 hours notice,** will be considered a No Show and charged a **$35.00** fee.
- The fee is charged to the patient, not the insurance company, and is **due upon receipt of the invoice.**
- As a courtesy we provide reminder phone calls and text messages to patients with the option to reschedule upon receipt.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. Please contact our office should this occur. You may contact Associates in Urogynecology 24 hours a day, 7 days a week at the number below. You may leave a voicemail if after hours. Messages left are acceptable.

Associates in Urogynecology 407-286-6190
70 W. Gore St. #201, Orlando, FL 32806

I have read and understand the Cancellation/No Show Policy and agree to its terms.

Patient's Name_____

Patient's Signature_____

Date_____