UroGynecology SPECIALTY CENTER

A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

7050 N Recreation Ave Suite 105
Fresno, Ca 93720
(559) 321-2930 FAX (559) 321-2940

7095 N Chestnut Ave Suite 102
Fresno Ca 93720
(559) 321-2930 Fax (559)298-7875

Patient Information

Last Name	First Name	Middle Name	
Street Address	City	State	Zip Code
Home Telephone Number / Cell phone Number	Work Telephone		Patient's Age
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Security Number		Date of Birth / /
Occupation	Employer		
Emergency Contact Name	Relationship to Emergency Contact	Emergency Contact Telephone	
Email Address	Patient's Pharmacy		

Insurance / Insured Information

Name of Insured / Responsible Party/Guarantor (If different from patient)	Telephone Number	Work Phone / Cell Phone	
Street Address	City & State	Zip Code	
Marital Status of Insured ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Security Number	Sex M F / Age	Date of Birth / /
Patient's Relationship to the Insured ☐ Insured ☐ Spouse ☐ Child ☐ Other	Occupation		
Employer	Employer's Address		

Name of Insurance	ID Number	Group Number	Plan Number
Name of Secondary	ID Number	Group Number	Plan Number

Referring Physician	**Primary Care Physician**
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:

Who should we thank for the referral?

☐ Referring Physician listed above ☐ Website ☐ Other: _____ ☐ Friend / Family Member: _____

Assignment of Benefits - I hereby assign all medical and surgical benefits to which I am entitled, including government programs, private insurance, major medical benefits and any other health plan, to Urogynecology Specialty Center. 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 necessary to secure payment.

Signature of Patient	Date

PATIENT MEDICAL HISTORY

PAST SURGICAL HISTORY

Hysterectomy: Year: _____

☐ Abdominal ☐ Vaginal ☐ Laparoscopic

☐ Robotic

Removal of Ovaries: ☐ Left ☐ Right ☐ Both

Heart Surgery:

Year: _____ Type: _____

Appendectomy:

Year: _____ Type: _____

Gall Bladder:

Year: _____ Type: _____

Bladder Surgery:

Year: _____ Type: _____

Rectal Surgery:

Year: _____ Type: _____

Other Surgery: _____

_____

_____

Patient Name: _____

DOB: _____

Date of service: _____

PAST OBSTECTRICAL/GYNOCOLOGIC HISTORY

Who is your OB/GYN? _____

When was your last pap smear? _____

Was it normal? Yes No

When was your last mammogram? _____

Was it normal? Yes No

Last gynecological exam: _____

Was it normal? Yes No

Date of menopause: _____

Number of pregnancies: _____

Number of deliveries: _____

Number of vaginal: _____

Number of C-sections: _____

SOCIAL HISOTRY

Tobacco use: ☐ Yes ☐ No # of years _____

If yes, amount (packs per day): _____

Alcohol use:

☐ Yes ☐ No _____

Drug use: ☐ Yes ☐ No _____

Caffeine use: ☐ Yes ☐ No _____

CURRENT MEDICATIONS/ALLERGIES

List all current medications: _____

_____

_____

_____

_____

ALLLERGIES: ☐ No ☐ Yes: _____

_____

_____

_____

_____

Urinary Symptoms

Are you experiencing any of the following urinary symptoms?

Dysuria (painful urination) ☐ Yes ☐ No

Urinary frequency ☐ Yes ☐ No If yes, how many times per day? _____

Urgency ☐ Yes ☐ No

Nocturia (waking up to urinate) ☐ Yes ☐ No If yes, how many times per night? _____

Post void fullness (feeling the need to urinate further after urinating) ☐ Yes ☐ No

PATIENT MEDICAL HISTORY

FAMILY HISTORY

Diabetes: ☐

Heart Disease: ☐

High Cholesterol: ☐

High Blood Pressure: ☐

Multiple Sclerosis: ☐

Cancer: ☐ Breast ☐ Ovarian ☐ Endometrial

☐ Kidney ☐ Cervical ☐ Colon

☐ Bladder ☐ Other: _____

Mother: ☐ Living ☐ Deceased _____

Father: ☐ Living ☐ Deceased _____

Siblings:

No. Living: ☐ No. Deceased: ☐ Cause: _____

MR #: _____

Date of Birth: _____

Visit Date: _____

Last Name: _____

First Name: _____

HEART CONDITIONS

☐ Murmur ☐ Palpitations ☐ Enlarged Heart

☐ Other: _____

_____

PATIENT'S HISTORY

Diabetes:	**Neuro:** ☐ Stroke ☐ Parkinson's	**Cancer:** ☐ Bladder ☐ Kidney
☐ None	☐ Peripheral Neuropathy ☐ Sciatica	☐ Vulvar ☐ Ovarian ☐ Breast
☐ Insulin-Dependent	☐ Spinal Stenosis ☐ Multiple Sclerosis	☐ Colon ☐ Endometrial ☐ Cervical
☐ Non-Insulin-Dependent	☐ Herniated Disc ☐ Lower Back Surgery	☐ Other _____
	☐ Lower Back Pain ☐ Other: _____	

☐ HTN ☐ Chronic Cough ☐ Bowel Surgery/Resection ☐ Hiatal Hernia/Reflux

☐ High Chloesterol ☐ Asthma ☐ Bladder/Renal Surgery ☐ Fibromyalgia ☐ Heart Attack

☐ Irritable Bowel Syndrome ☐ Pelvic Radiation ☐ Depression Coronary Artery Disease

☐ Chronic Obstructive Pulmonary Disease/Emphysema ☐ Alzheimer's/Cognitive ☐ Glaucoma

☐ Inflammatory Bowel Disease/ Crohn's ☐ Abdominal Wall Hernia

☐ Other _____

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Bladder Health Questionnaire

How bothered are you by the following incidents

		Not at all	A little bit	Somewhat	A great deal
1.	Frequent urination during the daytime hours?	☐	☐	☐	☐
2.	A sudden or uncontrollable urge to urinate with little or no warning?	☐	☐	☐	☐
3.	Accidental loss of urine?	☐	☐	☐	☐
4.	Urine loss due to a strong desire to urinate?	☐	☐	☐	☐

Please answer the following questions

		0-1	2-4	5 or more
5.	How many times are you getting up to void per night?	☐	☐	☐

6. What Overactive Bladder (OAB) treatments have you tried (check all that apply)?

☐ Absorbent pads ☐ Behavioral modification (fluid management, dietary changes, bladder training)

☐ Biofeedback ☐ Pelvic muscle exercises (Kegel exercises)

7. Which OAB drugs have you taken and for approximately how long? (check all that apply & write length taken next to drug name)

☐ Enable:®___ ☐ Flomax® _____ ☐ Detro _____ ☐ Ditropan _____

☐ Sanctura® ___ ☐ Toviaz® _____ ☐ Vesicare _____ ☐ Other _____

8. Have you experienced any intolerable side-effects from taking drugs to treat OAB (i.e., dry mouth, constipation, mental confusion, etc.)? Yes No

9. Which of these statements apply to you? {check all that apply)

☐ I have a pacemaker or implanted defibrillator

☐ I am pregnant or plan on becoming pregnant over the next 1-3 months

☐ I have nerve damage that could impact the tibial nerve or pelvic floor function

☐ I bleed excessively

☐ I have a hip replacement

10. Would you be interested in learning more about a non-surgical, non-drug treatment for your Overactive Bladder symptoms? Yes No

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Name: _____ **Email:** _____

DOB: _____

Please answer the following questions on the front and back of this paper to the best of your ability.

1. I leak urine when I cough, sneeze, exercise, or move suddenly.	**YES**	**NO**
2. I feel the urge and need to urinate even when my bladder is not very full.	**YES**	**NO**
3. I leak during sexual intercourse.	**YES**	**NO**
4. Do you feel "loose" vaginally since childbirth and/or menopause?	**YES**	**NO**
5. Do you feel dry during intercourse?	**YES**	**NO**
6. Do you have trouble reaching orgasm?	**YES**	**NO**
7. Have you ever "not quite made it" to the bathroom on time?	**YES**	**NO**
8. I feel that my genital area is visible under tight clothes.	**YES**	**NO**
9. Have your intimate relationships suffered due to these changes?	**YES**	**NO**
10. Are you experiencing a loss of self-confidence? Loss of interest in sex? Loss of desire?	**YES**	**NO**
11. am interested in non-surgical vaginal rejuvenation.	**YES**	**NO**

Thank you for taking the time to complete this questionnaire.

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Release of Medical Information to Friends and Family

Patient Name: _____

Telephone: _____ Fax: _____

CONSENT

I give the physicians and staff of UroGynecology Specialty Center (UGSC) permission to discuss my treatment, diagnostic tests and medical condition with the below listed family members and friends:

1. I understand that if I wish individuals be added or deleted from this list that I must notify UGSC in writing.
2. I understand that if my telephone and fax number changes, I must notify UGSC in writing.

AUTHORIZATION

I authorize the preceding release of information to the following people:

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

I authorize UGSC to fax test results to me. ☐ Yes ☐ No

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED

Patient's Name – Print: _____

Patient's Signature: _____

Date: _____

All charges are payable at the time of service unless we are a contracting provider with your insurance carrier. This will help us control our costs and fees. Upon payment, a receipt that is accepted by insurance companies will be issued to you.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to Urogynecology Specialty Center. The assignment will remain in effect until revoked to me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

Lab studies collected in our office are submitted to specific labs as directed by your insurance company. It is the patient's responsibility to inform our office if your insurance company requires a specific lab; otherwise the patient will be responsible for lab services not covered by your insurance company.

I understand that I am financially responsible for all charges.

Signed: _____ Date: _____
(patient or guardian if minor)

Patient's Name: _____ HIC Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Urogynecology Specialty Center for any services furnished to me, physician, or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signed: _____ Date: _____
(patient or guardian if minor)

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Phone: 559-321-2930
Fax: 559-321-2940

PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Jason Meade, DO or Benjamin Steinberg, DO may refer you to Fresno Surgical Hospital ("Hospital"). The address of the Hospital is 6125 N. Fresno Street Fresno, CA 93710 .

In connection with any referral to the Hospital, you are hereby advised that Jason Meade, DO and Benjamin Steinberg, DO has an investment interest in the Hospital.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Fresno Surgical Hospital. You will not be treated differently by your physician or Fresno Surgical Hospital if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact Melissa Aguirre at 559-321-2930.

By signing below, you acknowledge that should you be referred to the Hospital, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility. Lastly, you further acknowledge by signing below that you signed a Physician Ownership Disclosure Form prior to Dr. Jason Meade's or Dr. Benjamin Steinberg's referral of you to the Hospital.

Date: _____, 20___

Signature of Patient:

Printed Name of Patient: _____

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Thank you for choosing our healthcare services. We are dedicated to delivering quality and affordable care to our patients. In order to address inquiries and ensure clarity regarding patient and insurance responsibilities for services rendered, we have developed the following payment policy. Please review it thoroughly, feel free to ask any questions. Please sign and initial in the space provided. A copy of this policy will be provided upon request.

PAYMENT/OFFICE POLICY

1. _____ **No Children Policy**: For the safety and privacy of all patients, we kindly request that arrangements for childcare be made during your visits to our office.
2. _____ **Insurance**: We participate in most insurance plans, including Medicare. Patients without coverage under our contracted plans are expected to make full payment at each visit until insurance coverage is verified. It is the patient's responsibility to be aware of their insurance benefits and coverage details.
3. _____ **Co-payments and Deductibles**: All co-payments and deductibles must be settled at the time of service as per your contract with your insurance provider. Failure to collect co-payments and deductibles may constitute fraud.
4. _____ **Non-covered Services**: Patients are responsible for the full payment of any services not covered by their insurance provider.
5. _____ **Proof of Insurance**: Patients must provide accurate and up-to-date insurance information before receiving services. Failure to provide correct information may result in the patient being responsible for the balance of the claim.
6. _____ **Claims Submission**: We will assist patients in submitting claims to their insurance providers. Patients are reminded that they are ultimately responsible for any unpaid balances, regardless of insurance coverage.
7. _____ **Secondary Insurance**: We will bill secondary insurance companies as a courtesy, but patients are responsible for any unpaid balances.
8. _____ **Coverage Changes**: Patients are required to inform us of any changes in their insurance coverage. Unpaid claims after 45 days may result in billing the patient directly.
9. _____ **Nonpayment**: Accounts past due by more than 90 days may be subject to collection actions, and patients may be discharged from the practice.
10. _____ **Financial Disclosure**: UroGynecology Specialty Center is a member of Santé Foundation Medical Group (SFMG) and I may receive a bill from SFMG for services provided by UroGynecology Specialty Center and/or the group’s providers.

11. _____ **Medical Debt***:* A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

12. _____ **Prior Authorizations**: If your insurance requires a prior authorization for diagnostic and other procedures we will assist you in this process but, it is your responsibility to see that one is obtained prior to receiving this service.

13. _____ **Payment Options**: We accept payment by exact cash, check, credit card, and debit card for your convenience.

14. _____ **Returned Checks**: A service charge of $25.00 will be applied for all returned checks.

15. _____ **Failed Appointments**: Patients who fail to show up for scheduled appointments may be charged a no-show fee as outlined in our policy. A 24-hour notice is required for rescheduling or cancellations.

    - For a missed Urodynamic study appointment, a $100 no-show fee will apply.
    - For missed Pelvic Floor Rehab appointments, a $200 no-show fee will apply.
    - For any other type of appointment, a $75 no-show fee will be charged.

16. _____ **Exceptions**: We understand emergencies may occur, and we may waive the no-show fee as a one-time courtesy at our discretion.

17. _____ **Insurance Authorization**: Patients authorize the direct payment of insurance benefits to the physician and release necessary information for claims processing.

18. _____ **Zero Tolerance Policy**: Verbal or physical abuse towards staff or doctors will not be tolerated and may result in discharge from the practice.

19. _____ **Open Payments Database**: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata .cms.gov

20. _____ **Disability/FLMA forms**: There is a processing fee of $30.00 for any and each form that requires a doctor's signature. This fee is not covered by insurance.

21. _____ **Surgical Cancellation Policy**: We kindly ask patients considering surgery to carefully select their surgery date. The scheduling process for surgery is intricate and time-consuming. Upon receiving a scheduled surgery and preoperative date, patients acknowledge that the surgery date has been specifically reserved for them. If patients are unable to fulfill preoperative requirements, including but not limited to bloodwork, medical, cardiac, and other necessary clearances in a timely manner, the scheduled

surgery will be cancelled. In such cases, a cancellation fee of $500.00 will be applied. This fee is solely the patient's responsibility, as it is not covered by insurance.

22. _____ **Rescheduling Surgery Policy**: Should the need arise to reschedule your surgery, we kindly request that you contact our office at least two weeks prior to your scheduled surgery date. Failure to do so will incur a rescheduling fee of $500. This fee is entirely the patient's responsibility and is not covered by insurance. Rescheduling requests will be subject to the doctor's discretion.

We are committed to providing exceptional care to our patients and appreciate your cooperation with our payment policy. Please do not hesitate to reach out if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name