UroGynecology
SPECIALTY CENTER
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTE HEALTH FOUNDATION

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT PLEASE GIVE OUR OFFICE A 24 HOUR NOTICE TO AVOID BEING CHARGED THE $75.00 OR $100.00 NO SHOW FEE Ph: (559) 321-2930

7050 N Recreation Ave Suite 105
Fresno Ca 93720
559 321-2930 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_____ ☐ 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 |
|---|---|
| | |

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# 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 _____

*This must be a part of H & P

# 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

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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.

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.

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**ASSIGNMENT OF BENEFITS**

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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)

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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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**DEAR PATIENT**:

Thank you for choosing us as your health care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, initial and sign in the space provided. A copy will be provided to you upon request.

**PAYMENT/OFFICE POLICY**

1. _____ **No Children Policy:** Due to the sensitive nature of visits and procedures as well as safety concerns, we ask that if you have children, you make alternative arrangements for childcare during your visits with our office.

2. _____**Insurance**: We participate in most insurance plans, including Medicare. **We are not contracted with Medi-Cal as primary.** If you are *not* insured by one of our contracted plans, payment in full is expected at each visit. If you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. *Knowing your insurance benefits is your responsibility.* Please contact your insurance company with any questions you may have regarding your coverage.

3. _____**Co-payments and deductibles**: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. _____ **Non-covered services**: Please be aware that some of the services you receive may be non-covered or not considered "reasonable and necessary" **by Medicare or other insurers**. You must pay for these services in full at the time of visit.

5. _____**Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance as proof of insurance and may request a copy of your driver's license. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

6. _____**Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. _____ **Secondary insurance:** As a courtesy to you we will bill your secondary insurance company once. If payment is not received within 30 days of the date of the secondary insurance billing, it will be your responsibility to pay UGSC.

8. _____**Coverage Changes**: If your insurance changes, please notify us so we can make the appropriate changes. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

9. _____**Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this 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. _____**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.

12. _____For your convenience, we accept payment by cash, check, credit card and debit card.

13. _____**Returned Checks:** There will be a $15.00 service charge for all returned checks.

14. _____**Failed Appointments:** If you fail to show up for ***ANY*** of your scheduled appointment(s) you will be charged a $75 no-show fee. ***A Urodynamic study no show fee of 100.00. For Pelvic floor rehab no show fee is $200.00.*** We do require a 24 hour notice for any rescheduling or cancellations. As a courtesy our office sends out text message reminders three days prior to your scheduled appointment.

15. _____I hereby authorize my insurance benefits to be paid directly to the physician and authorize the release of information required for processing my claims.

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16. _____ **Zero Tolerance Policy:** We hold ourselves to the highest standards and respect for our patients. We appreciate the same courtesy back to our staff and doctors. Any conduct of verbal or physical abuse to staff or doctors can result in being discharged from the practice.

17. _____ Notice to Patients About 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

18. _____**Surgical cancellation**: For those patients who are considering surgery, please be mindful when selecting your surgery date. Scheduling surgery is time consuming and very complex. Upon being given a surgery and pre op date, you understand that a surgery date has been reserved specially for you. If you are unable to obtain preoperative requirements, such as bloodwork, medical, cardiac and any other clearances in a timely matter, surgery will be cancelled and fee of 500.00 with be administrated. This fee is 100% patient's responsibility, insurance does not cover fee. All preoperative requirements are due by the day of preop.

19. _____ **Rescheduling Surgery Policy**: In the event of needing to reschedule, please contact our office no later than 2 weeks prior to your surgery date. Failure do so will result in a fee of 500 dollars. This fee is 100% percent patient's responsibility, insurance does not cover fee. Rescheduling will solely be upon doctor's discretion.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charge for our area. Thank you for understanding our payment policy. Please let us know if you have any question 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