FLORIDA BLADDER INSTITUTE

Specialized Diagnostic, Treatment and Rehabilitative Care for Women with Incontinence, Pelvic & Bladder Disorders

1890 SW HEALTH PARKWAY, SUITE 205, NAPLES, FL 34109 OFFICE: 239-449-7979 FAX: 239-593-3356

Urogynecology New Patient Information

Name: _____
First Last Maiden

Address: _____

Permanent Address (if different from above): _____

City, State, Zip: _____

Social Security Number: _____ Birth Date: _____ Marital Status: S M W D SEP

Ethnicity: 1) Hispanic ☐ 2) Non-Hispanic ☐ 3) I prefer not to disclose ☐ Preferred Language: _____

Home # _____ Work # _____ Cell # _____

Consent to receive automated calls: ☐ Yes ☐ No Consent to receive text messages: ☐ Yes ☐ No

Email: _____

May we send you medical information via your e-mail? ☐ Yes ☐ No

Referred By: _____

Pharmacy Name and Address: _____ **Pharmacy Phone#:** _____

Patient's Employer: _____

Spouse/Parent Name: _____ Spouse's DOB: _____

Spouse's Employer: _____

Work # _____ Cell # _____

Spouse's S.S. # _____ Person Responsible for Bill: _____

All payments are due at the time of service. Charges will be billed to your insurance carrier.

Forms of payment accepted: Cash, Check, Money Order, Visa, MasterCard, American Express, and Discover.

How do you intend to pay for today's visit? _____

Emergency Contact: _____ Phone # _____

Insurance Company: _____ Medicare: _____ Medicaid: _____

Policy Holder: _____ Policy Holder's SS# _____ DOB: _____

Policy Holder's Employer: _____

Relationship to Patient: _____ Policy/ID # _____ Group/Account # _____

SECONDARY INSURANCE COVERAGE?

Insurance Company: _____ Policy Holder: _____

Policy/ID # _____ Group/Account # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Florida Bladder Institute to furnish information to all insurance carriers concerning my illness and treatments and hereby assign all payments for medical services rendered to myself or my dependents to Florida Bladder Institute. I understand that I am responsible for any amount not covered by my insurance. In the event that an outside collection agency is necessary to enforce payment of the account, I agree to pay for all collection fees deemed reasonable.

_____
Patient Signature Date

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Who referred you to see us today? ☐ Hospital or urgent care ☐ Internet ☐ Friend ☐ Self ☐ Medical Provider

Name of Referring Provider _____ May we request records from this provider? ☐ Yes ☐ No

Allergies. Please list all allergies to medications and associated reactions.

Allergy	Reaction

Allergic to Latex? ☐ Yes ☐ No Allergic to Betadine? ☐ Yes ☐ No

Medications. Please list all current medications.

Name of Medication	Dose	Reason

☐ Check here if medication list continues onto the back of the page.

Social History.

How many servings of the following do you consume each day: ____ Alcohol ____ Caffeine ____ Water

☐ Never smoker ☐ Former smoker. Quit __ years ago. ☐ Current smoker. __ packs per day

Family Medical History. Please indicate which family member has been diagnosed with the following.

M – mother, F – father, S – sister, B – brother, MG – maternal grandparent, PG – paternal grandparent

☐ Bladder Cancer
☐ Breast Cancer
☐ Colon Cancer
____ Kidney Cancer
☐ BRCA Positive
☐ Pancreatic Cancer
☐ Ovarian Cancer
☐ Liver Disease
____ Bleeding/clotting disorder
____ Diabetes
☐ Kidney Disease
☐ Heart Disease

Personal Medical History. Check each that you have or have had in the past.

☐ Anemia
☐ Anesthesia Complications
☐ Arthritis
☐ Bleeding/Clotting Disorder
☐ Blood Transfusion
☐ Cancer: Type _____
☐ Diabetes
☐ DVT/PE
☐ Endometriosis
☐ Fibromyalgia
☐ GI Problems
☐ Headaches/Migraines
☐ Heart Disease
☐ Hepatitis/Liver Disease
☐ Hypertension
☐ Insomnia
☐ Interstitial Cystitis
☐ Kidney Disease
☐ Lung Disease
☐ Neurological Disorder
☐ Psychiatric Illness
☐ Seizure Disorder
☐ Stroke/TIA
☐ Thyroid Issues

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Surgical History.

☐ Hysterectomy	☐ Prolapse repair	☐ Appendectomy	☐ Spine surgery
☐ Removal of tubes/ovaries	☐ Bladder surgery	☐ Cholecystectomy	☐ Brain surgery
☐ Hernia repair	☐ Sling	☐ Colon surgery	☐ Orthopedic surgery

Other surgeries: _____

_____

Brief OB/GYN History.

Total number of pregnancies: ____ Vaginal/Natural deliveries: ____ C-sections: ____ Forceps or vacuum deliveries? ☐Yes ☐No

Have you experienced menopause? ☐Yes ☐No Are you taking hormone replacements? ☐Yes ☐No

Have you ever had an STD? ☐Yes ☐No If yes, please specify _____

Are you sexually active? ☐Yes ☐No If not, please explain why _____

Bladder and Bowel Function Questionnaire.

How often do you urinate? Every ___ hours during the day. ___ times at night.

Do you lose urine in spurts with laughing, sneezing or exertion? ☐Yes ☐No Amount: ☐Small ☐Large ☐Varies

Do you lose urine with a strong sense of urgency? ☐Yes ☐No Amount: ☐Small ☐Large ☐Varies

Do you lose urine without warning (without activity or urgency)? ☐Yes ☐No

Do you wear pads during the day? ☐Always ☐ Sometimes ☐Never Do you wear pads at night? ☐Always ☐Sometimes ☐Never

Does your urinary stream seem weak or slow? ☐Yes ☐No

Is it difficult to start your urinary stream? ☐Yes ☐No

Do you feel like you empty your bladder completely? ☐Yes ☐No

Do you have pain associated with urination? ☐Yes ☐No Do you ever see blood in your urine? ☐Yes ☐No

Do you experience frequent bladder infections? ☐Yes ☐No

Do you feel as if your pelvic organs are "falling down?" ☐Yes ☐No Do you feel a bulge at the opening of your vagina? ☐Yes ☐No

How frequently do you have a bowel movement? ___ times/day OR ___ times/week

Do you have trouble with constipation? ☐Yes ☐No

Do you ever experience accidental leakage of stool? ☐Yes ☐No

Have you tried any treatments for the above issues? ☐Yes ☐No

I have tried (medications, lifestyle changes, diet changes, exercises) _____

_____

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Consent for Purpose of Treatment, Payment or Health Care Operations And Medical Information Release

I consent to the use or disclosure of my protected health information by Florida Bladder Institute (FBI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of FBI. I understand that diagnosis or treatment of me by FBI may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. FBI is not required to agree to the restrictions that I may request. However, if FBI agrees to a restriction that I request, the restriction is binding on FBI practice. I have the right to revoke this Consent, in writing, at any time, except to the extent that FBI practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information is information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Notice of Privacy Practices for FBI prior to signing this document. Notice of Privacy Practices for FBI has been provided to me.

The Notice of Privacy Practices for FBI practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of FBI health care operations.

A summary of the Notice of Privacy Practices for FBI is also posted in the waiting room.

This Notice of Privacy Practices for FBI also describes my rights and the duties of FBI practice with respect to my protected health information.

FBI reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for FBI. I may obtain a revised Notice of Privacy Practices for FBI by contacting the office of FBI at 1890 SW Health Parkway, Suite 205, Naples, FL 34109 or by calling (239) 449-7979.

Release of Medical Information: If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of information each person may receive by checking the items we may release.

Name	Relationship	Type of information which may be released		
_____	_____	☐ All Info	☐ Appts Only	☐ Billing
_____	_____	☐ All Info	☐ Appts Only	☐ Billing
_____	_____	☐ All Info	☐ Appts Only	☐ Billing

_____ **No Information to Be Released**

Name of Patient / Representative (Please Print):_____Date: _____

Signature of Patient or Representative: _____Employee Initials:_____

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Financial Information

As a courtesy to you, we will be happy to bill your insurance company for services rendered. If for any reason your insurance company denies the claim, you will be personally responsible for the charges. **A credit card is required to be kept on file for any charges not covered by insurance. Due to the thousands of insurance plans available it is impossible for us to know the coverage details of all of the policies. It is your responsibility to know what type of coverage, benefits, deductibles and co-payments you have with your insurance plan.**

Well Woman Exam: Most insurance companies do not cover more than one routine well woman exam per 365 day period. If you have had this service provided by another provider within the last 365 days you will be responsible for paying for today's visit.

Pathology Notice: Certain tests that you have done in the office will be sent to a pathologist for diagnostic evaluation. The pathologist will submit a bill to your insurance company and bill you directly if there is a balance due.

Phone Calls: We encourage you to use the patient portal* to communicate with your provider concerning health questions. Communication through the patient portal is more efficient and does *not* incur a charge to you. Phone calls regarding health concerns *will* incur a charge. The charge will vary from **$30** to **$90** depending on the length of the call.

Surgery Cancellation Policy: A fee of **$500.00** will be charged if you cancel a scheduled surgical procedure with less than a 10 day notice.

No Show and Late Arrival Policy: A fee of **$50.00** will be charged for Consecutive "No Show" Appointments. Subsequent occurrences may results in dismissal from the practice. If you are more than **10 minutes late**, the appointment will be rescheduled.

Assignment to Pay for Services: I agree to pay the Florida Bladder Institute & Especially for Women for all charges for services rendered today, or any future date of service, in this office. I understand that any unpaid charges will be billed to my credit card. Any refunds needing to be issued back in the form of a check will be charged a 3% finance fee. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney's fees and/or court costs.

I agree with all of the statements above.

Signature of Patient or Responsible Party _____ Date _____

***Make Appointments, Send Messages, Access Your Health Records & See Your Billing Statements 24 Hours A Day On The Patient Portal Found On Our Website WWW.FLORIDABLADDERINSTITUTE.COM**

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In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show and Late Arrival Policies as follows.

Effective May 1, 2017 we will implement a "no-show" policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence – Patient will receive a letter advising of our policy.
- Second occurrence – Patient will receive a 2nd letter and a $50.00 no show fee assessment
- Third and subsequent occurrences – May result in dismissal from practice and additional $50 no show fee

If a patient is more than **10** minutes late for an appointment, the appointment will be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

New patients are encouraged to log on to the patient portal and fill out Demographics and Medical History prior to coming in. Otherwise, **new patients are required to arrive at the office 30 minutes prior to the scheduled appointment to complete the paperwork.** If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time or even reschedule your appointment.

Thank you,
Florida Bladder Institute and Especially for Women

Signature: _____ Date _____

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Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have **All** pelvic examinations **performed at this office** and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ ____/____/_____
Signature Date

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