UROGYNECOLOGY & HEALING ARTS
AEUMURO G. LAKE, MD FACOG, FPMRS

X_gender neutral/free

PT. NAME _____ M___ F___ DOB _____ AGE _____
Last First MI

SOCIAL SECURITY # _____

ADDRESS _____ YOUR OCCUPATION _____

CITY/STATE _____ ZIP _____ YOUR EMPLOYER _____

HOME PHONE ( ) _____ SPOUSE'S NAME _____ DOB _____

WORK PHONE ( ) _____ SPOUSES OCCUPATION _____

CELL PHONE ( ) _____ SPOUSES EMPLOYER _____

REFERRED BY _____ PRIMARY CARE PHYSICIAN _____

PRIMARY INSURANCE _____ **SECONDARY INSURANCE** _____

Insured _____ DOB _____ Insured _____ DOB _____

Employer _____ Employer _____

Relationship to patient _____ Relationship to patient _____

Insured ID No. _____ Insured ID No. _____

Group No. _____ Group No. _____

E-Mail Address: _____

BILLING: If person responsible for bill is **other than above patient,** please complete.

NAME _____ SS# _____
Last First MI

OCCUPATION _____

Relationship to patient _____ EMPLOYER _____

ADDRESS _____ ADDRESS _____

CITY/STATE _____ ZIP _____ CITY/STATE _____ ZIP _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

Patient has received "PATIENTS RIGHTS AND RESPONSIBILITIES". YES ☐

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.

NAME _____ PHONE _____ RELATIONSHIP _____

INTERPRETER INFORMATION: In case we need to notify patient or pass on a message.

NAME _____ PHONE _____

Please read the following statement carefully before signing.

1. I authorize treatment of the person named above and agree to pay all fees for such treatment.
2. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I acknowledge there is a **$35.00 fee on checks returned from my bank.** Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with **1.5% interest per month** on the unpaid balance.
3. I authorize AeuMuro G. Lake, MD FACOG, FPMRS and their agents to release any medical information acquired in the course of my examination or treatment to process my insurance claims.

SIGNATURE _____ RELATIONSHIP TO PATIENT _____

DATE _____

Urogynecology & Healing Arts PLLC

HEALTH HISTORY
(PLEASE PRINT)

Date: _____

GENERAL INFORMATION:

Patient Name:
_____
Age: _____ Date of Birth: _____
Weight: _____ Height: _____
Preferred Language: _____

Pharmacy (phone and address):
_____
Referring physician or health professional:
_____
Primary Care Physician:
_____

Reason and Goal for Visit:
_____

Date Problem began:
_____

Have you had treatment for this problem before? Yes No
_____

Medications you are currently taking:

Prescription Name	Dose

Allergies & reaction it causes: (e.g. Drug, Food)

(Attach additional page if needed)
Have you or are you currently taking drugs not prescribed to you: Yes No
If yes, describe: _____

Prior Major Illnesses and Injuries, (e.g. high blood pressure, diabetes, depression/anxiety)

History of Tobacco Use: Yes No Socially
If Yes, when did you quit? _____

Surgical History

Type of Surgery/Procedure	Date/Year

Alcohol Use: Yes No Occasionally Socially
Illegal Drugs: Yes No Occasionally Socially

Ob/Gyn History:
Last Menstrual Period/Age of Menopause: _____
Sexually Active: Yes No
Do you have pain with intercourse: Yes No
History of sexual trauma/abuse: Yes No
Total: Pregnances_____ Vaginal deliveries _____

Have you had bleeding after menopause: Yes No
Last Pap Smear Test: _____Was it Normal? Yes No
Last Colonoscopy: _____Was it Normal? Yes No
History of kidney stones? Yes No

Cesarean deliveries_____ # of Living Children _____

Urogynecology & Healing Arts PLLC

Family History:

Please indicate whether you or your immediate relatives (mother, father, siblings, grandparents, aunts/uncles, children) currently *have or have had* in the past the following illnesses:

Illness	Yes	No	Relative	Illness	Yes	No	Relative
Breast Cancer				Obesity			
Ovarian Cancer				High Cholesterol			
Uterine Cancer				Pulmonary Embolism			
Colon Cancer				Blood Clot (Deep Venous Thrombosis			
Bladder Cancer				Recurrent urinary tract infections			
Kidney Cancer				Kidney stones			
Heart Attack				Osteoporosis			
Stroke				Alzheimer's Disease			
Diabetes				Mental Illness			
Hypertension/High Blood Pressure							

☐ Family History Unknown

REVIEW OF SYSTEMS

Have you had or do you have any of the conditions listed below?

- ☐ Fever/Chills
- ☐ Fatigue
- ☐ Diabetes
- ☐ Heat intolerance
- ☐ Thyroid problems
- ☐ Chest pain
- ☐ Cough
- ☐ Shortness of breath
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Rectal bleeding
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Easy bruising
- ☐ Swollen glands
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Back problems
- ☐ Muscle aches
- ☐ Painful joints
- ☐ Skin lesions
- ☐ Skin itching
- ☐ Balance difficulty
- ☐ Headaches/migraines
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Anxiety
- ☐ Depressed mood

Miscellaneous Questions:

-Do you consider your health to be: Excellent Good Fair Poor

-In the last 2 weeks, have you had little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day Decline to specify

-In the past 2 weeks, have you been feeling down, depressed, or hopeless? Not at all Several days More than half the days Nearly every day Decline to specify

Do you exercise? Yes No What type of exercise? _____.

Consumption of caffeine-containing beverages (coffee, tea, cola): _____# of cups per day.

Have you had unexpectedly lost or gained weight recently? Yes No Usual Weight _____

****

I_____ certify that the above information is correct to the best of my knowledge. I will not hold Dr. AeuMuro G. Lake or members of her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Patient Name/Legal Guardian Date

_____ _____

Reviewed By Date

Urogynecology & Healing Arts PLLC

OFFICE POLICY CONSENT

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

All patients are required to complete our registration form, provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients; however, the balance is your responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be your responsibility. Please be aware that some services provided may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time service s rendered.

Some visits are performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

We ask 24-48 hours to process prescription requests and prescription refills. We use "Rx eligibility," which enables us to have electronic access to prescriptions filled at your preferred pharmacy(s).

If you are calling to make an appointment from a referring physician and your insurance requires a referral to be seen, please allow at least 3 business days prior to appointment to assure we receive the authorization. If you choose to be seen without proper authorization, you will be given a waiver to sign stating that you are aware authorization has not been received and would like to be seen. You will be responsible for any charges your insurance denies because of un-authorized visit.

There is a fee for copied medical records. We will notify you of the records fee and will require payment in full prior to the release of records. We require at least 5-10 business days to receive records and make copies.

Should you arrive late to your appointment, you may be asked to reschedule or you may have to wait to be seen between or after other patients who have arrived on time.

Unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $50.00. Please help us better serve you better by keeping your scheduled appointments.

I, have read, understand and agree to the office policy of Urogynecology & Healing Arts, PLLC.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Date

Urogynecology & Healing Arts PLLC

Health Insurance Portability and Accountability

This consent form allows Urogynecology & Healing Arts to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Urogynecology & Healing Arts has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Urogynecology & Healing Arts.

_____ I hereby authorize that Urogynecology & Healing Arts may leave messages on my voicemail to confirm Initial appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.
___ cell phone ___ home phone ___work phone

_____ I hereby authorize that Urogynecology & Healing Arts may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Urogynecology & Healing Arts may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Urogynecology & Healing Arts may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carryout treatment, payment and health care operations, and must be provided by me in writing. I understand that while Urogynecology & Healing Arts is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Urogynecology & Healing Arts may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Patient _____ **Date**_____

Signature of Parent (if minor) / Authorized Representative_____ **Date**_____

Urogynecology & Healing Arts PLLC

FINANCIAL POLICY

Thank you for choosing Urogynecology & Healing Arts to meet your medical needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy, which we request that you read and sign.

Co-pays and payment for services **before deductible is met** are due at the time services are rendered. For your convenience, we accept exact cash, checks, and major credit cards. If billed for copayment, a **surcharge of $20.00** will be assessed in addition to the copayment amount.

Returned checks will be charged a twenty- five dollar ($25.00) handling fee. Balances over thirty (30) days will be subject to a handling fee of five dollars ($5.00). A minimum charge of fifty dollars ($50.00) will be made for missed appointments and appointments cancelled less than twenty-four (24) hours in advance.

If you have insurance, we will help you receive your maximum allowable benefits; however, **you remain responsible for your co-pay and for payment if your claim is rejected.** Sixty (60) days from the date of service is a reasonable amount of time for the insurance company to make a decision as to whether they will pay any of the submitted claim. **You will be responsible for the entire bill that has not been paid within the sixty (60) day period from the date of service.**

If you should desire treatment with a pessary, a medical device used to treat prolapse and leakage of urine, the cost to you will be $140 per pessary ordered. We do not bill insurance for this device.

Consultations extending beyond 30 minutes will be billed using extended time codes. Please be aware that your insurance may or may not pay for these codes. **You will be responsible for any of the bill that your insurance does not pay.**

Recent delays and loss of mail by the United States Postal Services has resulted in some patients not receiving billing statements. Urogynecology & Healing Arts will not be responsible in such conditions. Accounts with outstanding balances will be charged handling fees for delay of payment by 30 days or greater. **Please call our billing office *(425-228-5228)* within 3-4 weeks of your appointment to ensure you have paid any owed balance on your account and with any other questions regarding your bill.**

I hereby confirm that I have read the above payment policy and agree to accept it.

Patient Name (Printed):_____

Patient Name (Signed):_____

Date: _____