Urogynecology & Healing Arts PLLC

REGISTRATION

(Please Print clearly)

Today's date: | PCP/Location:

PATIENT INFORMATION

Patient's Last name: | First: | Middle:

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ gender free/neutral ❑ M ❑ F

Preferred Pronouns: ❑ he/him ❑ she/her ❑ they/them

Street address: | Social Security no.: | Cell: ( ) | Home: ( )

P.O. Box: | City: | State: | ZIP Code:

Email Address: | Prefer Appoint Reminders by: _____ Text or ____ Voicemail

Occupation: | Employer: | Preferred Language:

Referred to clinic by (please check one box): ❑ PCP ❑ Urgent care/Emergency ❑ Family/Friend ❑ Online Advertisement ❑ Online Search/Self-referred ❑ Other

INSURANCE INFORMATION

(Please provide your insurance card and ID for a copy to be made.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home/Cell phone no.: ( )

Occupation: | Employer:

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name: | Subscriber's S.S. No.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Urogynecology & Healing Arts or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Urogynecology & Healing Arts PLLC

HEALTH HISTORY

(Please print clearly)

Date: _____

GENERAL INFORMATION:

Patient Name:

_____

Date of Birth: _____

Weight: _____ Height: _____

Pharmacy (name and address):

_____

_____

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)

Surgical History (e.g. hysterectomy, ovary/ovarian cyst removal)

Type of Surgery/Procedure	**Date/Year**

History of Tobacco Use: Yes No Socially

If Yes, when did you quit? _____

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: Pregnancies_____ 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 _____

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

General Health and Depression Screening:

-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/Responsible Party Signature Date

_____ _____

Reviewed By [UHA Staff Signature only] Date

Urogynecology & Healing Arts PLLC

OFFICE POLICY CONSENT

Thank you for choosing Urogynecology & Healing Arts as your pelvic floor health care specialist. Our staff and physicians are committed to providing you the with state of the Art service. 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 any balance attributed to deductible, co-insurance, copay, or patient portion is your responsibility. Deductibles applied by your insurance, not covered by another (secondary) 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 is rendered.

If our practice/providers are out of network (OON) for your insurance, your visit will be a cash pay visit. If your insurance plan has OON benefits and you would like to submit a superbill to your insurance plan for consideration of (partial or full) reimbursement, please request a superbill and we will provide this to you either by mail or at your next office visit. We do not submit insurance claims to insurance plans for which we are out of network.

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 or prior authorization 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.**

Your medical record can be accessed via the patient portal. 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. Please help us better serve you better by keeping your scheduled appointments and arriving on time or early.

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

Patient Signature	**Date**
Responsible Party (if not patient)	**Date**

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 referred me to: https://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm , 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.

_____ [INITIALS] I hereby authorize Urogynecology & Healing Arts to **leave messages on my voicemail to confirm 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

_____ [INITIALS] I hereby authorize Urogynecology & Healing Arts to 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.

Patient Signature_____ **Date**_____

Responsible Party (if not patient)_____**Date**_____

Urogynecology & Healing Arts PLLC

FINANCIAL POLICY

Thank you for choosing Urogynecology & Healing Arts to meet your pelvic floor health needs. We are committed to providing you with state of the Art service. The following is a statement of our Financial Policy, which we request that you read and sign.

If you are using your insurance, we will help you receive your maximum allowable benefits; however, **you remain responsible for your co-pay, deductible, out of pocket expenses, and patient portion determined by insurance.** 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. Returned checks will be charged a twenty- five dollar ($25.00) handling fee.

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.

Your patience in receiving your billing statement (for both office and surgical treatments) is appreciated. As of September 1, 2022, we are transitioning to an electronic payment system. We believe this transition to electronic statements and payments will add convenience and clarity to our services and improve your overall experience with Urogynecology & Healing Arts.

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

Patient Name (Printed):_____
Patient/Responsible Party Signature:_____

Date: _____