Welcome to the Female Pelvic Health Center

Thank you for choosing our practice for all your Urogynecologic needs.

Please have ALL the attached paperwork filled out COMPLETELY BEFORE arriving to our office.

Please arrive 15 minutes prior to your scheduled appointment time.

Present your insurance card/cards, photo ID, copay and finished paperwork to the front desk. **If you are late to your appointment or do not have all paperwork filled out COMPLETELY, your appointment will be rescheduled.** Please plan accordingly for travel time and directions.

If your insurance requires a referral for a Specialist visit, be sure to call your Primary Care Physician at least 48 hours prior to your appointment day. If a valid referral is not received prior to your visit, you will be asked to reschedule your appointment.

As a courtesy to our practice we require 48 hours' notice if you need to cancel or reschedule your appointment. If you do not give us the time required, or if you are a no show, you will be charged a $250.00 cancellation fee.

Thank you for your cooperation, we look forward to meeting you!

FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY

THE FEMALE PELVIC HEALTH CENTER

www.fphcenter.com

Name	Date of Birth Month day year	Age
Address	City State Zip	
Home Phone	Work Phone	Cell Phone
Social Security #	Marital Status: M S W D	
How did you hear about us?	Email Address	

Emergency Information

Emergency Contact Name	Relationship	
Emergency Contact Home Phone	Work phone	Cell phone

Physician and Pharmacy Information

Referring Physician	Address	Phone Number
Primary Care Physician	Address	Phone Number
Gynecologist	Address	Phone Number
Pharmacy Name	Address	Phone Number

Patient Employer Information	Spouse's Information
Patient's Employer	Spouse's Name
Occupation	Spouse's Employer

Primary Insurance Information	
Name of Primary Insurance	Insurance ID#
Subscriber's Name	Group#
Subscriber's Date of Birth	Co-Pay $ Prescription Plan: Yes No

Secondary Insurance Information	
Name Of Secondary Insurance	Insurance ID#
Subscriber's Name	Group#
Subscriber's Date Of Birth	Co-Pay$ Prescription Plan: Yes No

The Female Pelvic Health Center
Medical Questionnaire

Name	Date of Birth	Age	Drug Allergies: ☐ yes ☐ no If yes, medication and REACTION:
Please describe the reason for your visit (chief complaint):			

Number of Pregnancies	Number of Vaginal Deliveries:	Number of Cesarean Deliveries
Forceps or vacuum? ☐ Y ☐ N	Episiotomy? ☐ Y ☐ N	Laceration/tear? ☐ Y ☐ N Degree? 1 2 3 4 unsure
Largest baby (wt)	Other complications? Prolonged labor?	Hysterectomy ☐ Yes ☐ No abdominal ☐ vaginal ☐ laparoscopic☐ Have ovaries been removed? Rt ☐ Lt ☐

GYNECOLOGIC HISTORY

Date of last menstrual period:	Do you experience any of the following? (check ones you have)
Date of last PAP smear: Normal?	_____ Bleeding between periods
Date of last mammogram: Normal?	_____ Heavy menstrual periods
Date of last colonoscopy: Normal?	_____ Pain with periods
Have you ever had a sexually transmitted disease: ☐Yes ☐ No If yes, what?	_____ Bleeding after intercourse
Are you sexually active at the present time: ☐ Yes ☐ No	_____ Pain with intercourse
Are you using contraception? ☐ Yes ☐ No If yes, what type?	_____ "Falling" of pelvic organs or prolapse Are you presently taking hormone replacement therapy? ☐yes ☐ No If yes, what medication and is it vaginal or oral:

MEDICAL CONDITIONS AND MEDICATIONS *Please list ALL your medical conditions, and medications*

MEDICAL CONDITIONS :	**MEDICATIONS & DOSAGE** (please include all vitamins and supplements)
Example: High Blood Pressure	*Example: Lopressor 10 mg 1x day*

Please answer questions below:

Do you have glaucoma? ☐ **YES** ☐ **NO** If yes, is it open/wide angle (or) narrow angle? _____
Are you Diabetic? ☐ **YES** ☐ **NO**
Do you take blood thinners (Coumadin, Plavix, Aggrenox, Pradaxa, etc) ☐ **YES** ☐ **NO**

Name: Date of Birth:

PAST SURGICAL AND HOSPITAL HISTORY: ☐ **None** ☐ **Yes, if yes**

Please describe your past experience with **operations**, serious injuries, and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries/hospitalizations.

FAMILY HISTORY

Are there medical events **in your family's history (not your history)**, including diseases that may be hereditary or place you at risk? Please mark **Y** or **N** for each condition (no blanks please ☺)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	High blood pressure	☐	☐	Heart disease	☐	☐	Thyroid disease
☐	☐	Stroke	☐	☐	Diabetes	☐	☐	Asthma
☐	☐	Kidney disease	☐	☐	Liver disease	☐	☐	Breast disease
☐	☐	Breast Cancer	☐	☐	Ovarian Cancer	☐	☐	Bleeding Problems
☐	☐	Other Cancer (indicate type)						

SOCIAL HISTORY

Marital Status:
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

Current Alcohol Use: ☐ YES ☐ NO
Current Drug Use: ☐ YES ☐ NO
History of drug/alcohol addiction:
☐ YES ☐ NO
# of Drinks/week: _____

Never Smoked: ☐
Former Smoker: ☐ Yes ☐ No
Current Smoker: ☐ Yes ☐ No
# of Cigarettes/day:_____

Highest Level of Education:

Employment (please include job title):

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Ethnicity: ☐ Latino/Hispanic ☐ Other

REVIEW OF SYSTEMS

Please mark box for **Yes** or **No** for any condition(s) you have had or that you have currently. (no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight loss	☐	☐	Chills	☐	☐			
Eyes:	Blurred vision	☐	☐	Double vision	☐	☐	Eye Pain	☐	☐
Ears/Nose/Mouth/Throat:	Hearing loss	☐	☐	Sore throat	☐	☐			
Cardiovascular:	Chest pain	☐	☐	Palpitations	☐	☐	Heart Murmur	☐	☐
Respiratory:	Chronic cough	☐	☐	Wheezing	☐	☐			
Gastrointestinal:	Nausea/Vomiting	☐	☐	Diarrhea	☐	☐	Bloody Stools	☐	☐
Musculoskeletal:	Arthritis	☐	☐						
Integumentary/Skin:	Rash	☐	☐						
Neurologic:	Seizure	☐	☐	Memory loss	☐	☐	Headache	☐	☐
	Neuropathy	☐	☐						
Psychiatric:	Depression	☐	☐	Anxiety	☐	☐			
Endocrine:	Hot flashes	☐	☐	Fatigue	☐	☐			
Hematologic/Lymphatic:	Easy bruising	☐	☐	Easy Bleeding	☐	☐			
Allergic/Immunologic:	Seasonal	☐	☐	Animal Dander / Foods	☐	☐	Asthma	☐	☐

Other:

The Female Pelvic Health Center

PELVIC FLOOR DISTRESS INVENTORY (PFDI)

NAME _____ DATE _____

Please answer each question by checking the best response. While answering these questions, please consider your **symptoms over the last 3 months**. We realize that you may not be having problems in some of these areas but please fill out **both sides** of this form as completely as possible.

Urinary Distress Inventory 6 (UDI-6)

Do you experience:	Yes (or) no Please circle	**If Yes,** how much does it bothers you? Please place in box 1-4, (1=not at all, 2=somewhat, 3=moderately, 4=quite a bit)
Usually experience frequent urination?	Yes No	
Usually experience urine leakage associated with a feeling of urgency, this is, a strong sensation of needing to go to the bathroom?	Yes No	
Usually experience urine leakage related to coughing, sneezing, or laughing?	Yes No	
Usually experience small amounts of urine leakage (that is, drops)?	Yes No	
Usually experience difficulty emptying your bladder?	Yes No	
Usually experience pain or discomfort in the lower abdomen or genital region?	Yes No	

Colorectal-Anal Distress Inventory 8 (CRADI-8)

Do you experience:	Yes (or) no Please circle	**If Yes**, how much does it bothers you? Please place in box 1-4, (1=not at all, 2=somewhat, 3=moderately, 4=quite a bit)
Feel you need to strain too hard to have a bowel movement?	Yes No	
Feel you have not completely emptied your bowel at the end of a bowel movement?	Yes No	
Usually lose stool beyond your control if your stool is well formed?	Yes No	
Usually lose stool beyond your control if your stool is loose?	Yes No	
Usually lose gas from the rectum beyond your control?	Yes No	
Do you usually have pain when you pass your stool?	Yes No	
Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes No	
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	Yes No	

Please complete other side →

Please complete other side →

NAME _____ DATE _____

Pelvic Organ Prolapse Distress Inventory 6 (POPDI-6)

Do you experience:	Yes (or) no Please circle	**If Yes**, how much does it bothers you? Please place in box 1-4, (1=not at all, 2=somewhat, 3=moderately, 4=quite a bit)
Usually experience pressure in the lower abdomen?	Yes No	
Usually experience heaviness or dullness in the pelvic area?	Yes No	
Usually have a bulge or something falling out that you can see or feel in your vaginal area?	Yes No	
Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	Yes No	
Usually experience a feeling of incomplete bladder emptying?	Yes No	
Ever have to push up on the bulge in the vaginal area with your fingers to start or complete urination?	Yes No	

Pelvic Floor Impact Questionnaire (PFIQ)

Instructions: Some women find that bladder, bowel, or vaginal symptoms affect their activities, relationships, and feeling. For each question place an **X** in the response that best describes how much you're activities, relationships, or feelings have been affected by your bladder, bowel, or vaginal **symptoms or conditions over the last 3 months.** Please make sure you mark an answer in **all 3 columns** for each question.

How do symptoms or conditions relate to the following →→→ Usually affect your ↓	***Bladder or Urine***	***Bowel or Rectum***	***Vagina or Pelvis***
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2. Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3. Entertainment activities such as going to a movie or concert?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4. Ability to travel by car or bus for a distance greater that 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5. Participating in social activities outside your home>	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
6. Emotional health (nervousness, depression, etc)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
7. Feeling frustrated?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

The Female Pelvic Health Center

Patient's Name_____ Date_____

New Patient Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire

Instructions: Following are a list of questions about you and your partner's sex life. All information is strictly confidential. Your confidential answers will be used only to help doctors understand what is important to patients about their sex lives. Please check the box that best answers the question for you. While answering the questions, consider your sexuality over the **past six months**. Thank you for your help.

☐ Sexually not active (Please do not fill out the rest of the form)

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex feeling frustrated due to lack of sex, etc.

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than Once a Month ☐ Never

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

4. How satisfied are you with the variety of sexual activities in your current sex life?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

5. Do you feel pain during sexual intercourse?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

6. Are you incontinent of urine (leak urine) with sexual activity?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

8. Do your avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out?)?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

10. Does your partner have a problem with <u>erections</u> that affects your sexual activity?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

☐ Always ☐ Usually ☐ Sometimes ☐ Seldom ☐ Never

12. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?

☐ Much less intense ☐ Less intense ☐ Same Intensity ☐ More intense ☐ Much more intense

FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY
THE FEMALE PELVIC HEALTH CENTER

Bladder Record

Please keep track of your fluid intake and urine output for two 24-hour periods. The 24-hour periods do not have to be consecutive days. Be sure to include a.m. and p.m. when documenting the time of day you urinate, and measure the amount you urinate in ounces or cc's. These markings can be found on a measuring cup. This record is very important in deciding the treatment for your bladder problems.

Day One

Time	Amount Voided	Amount of Leakage	Reason for Accident	Amount of Fluid I Drank

Number of pads or undergarments used today: _____ *Date:* _____

Bladder Record, *continued recorded information*

Day Two

Time	Amount Voided	Amount of Leakage	Reason for Accident	Amount of Fluid I Drank

Number of pads or undergarments used today: _____ *Date:* _____

THE FEMALE PELVIC HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS - WE ARE REQUIRED BY LAW TO

- Maintain the privacy of protected health information
- Follow the terms of our notice that is currently in effect
- Give you this notice of our legal duties and privacy practices regarding health information about you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, insurance companies, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminder, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster release effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special

approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries and illness.

Public Health Risks. We may disclose Health Information for public health *activities*. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities may include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION WE HAVE ABOUT YOU

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment of your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the office's Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the office's Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the office's Privacy Officer. **We are not required to agree to your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to the office's Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please ask the receptionist.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office's Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

Effective Sept 9, 2009 This Document is Available in Larger Print

FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY
THE FEMALE PELVIC HEALTH CENTER

760 Newtown Yardley Rd Suite 115 Langhorne, PA 18940
215-504-8900 Fax 215-504-8902

BLADDER SATISFACTION SURVEY

Name_____ Phone#_____

Which symptoms best describe you?

Frequent Urination- Day, Night. Or Both

Sudden or Strong Urge to urinate

Unable to Empty the Bladder

Leaking with Sneezing, Coughing, Exercising

Leaking with Urge or No Warning

Unable to make it to the bathroom in time

How long have you had these symptoms? _____

Have you tried medication to help your symptoms? Yes No

If yes, check the medications or treatments you have tried:

Oxybutynin (Ditropan, Ditropan XL)/Patch	Vibegron (Gemtesa)
Tolterodine (Detrol, Detrol LA)	Solifenacin Succinate (VESIcare)
Darifenacin Hydrobromide ER (Enablex)	Trospium (Sanctura, Sanctura XR)
Fesoterodine Fumarate ER (Toviaz)	Mirabegron ER (Myrbetriq)
Desmopressin (DDAVP)	Amitripytline (Elavil)
Pentosan polysulfate (Elmiron)	Bladder Instillations

Did these medications help your symptoms? Circle #

1	2	3	4	5	6	7	8	9	10

No Relief Completely Cured

If you've stopped taking you meds explain why:

Did not help Side Effects Too Expensive

Describe Side Effects_____

Behavior Modification Tried (i.e. caffeine, lifestyle, bladder training, physical therapy)

_____

What is your level of frustration with you bladder symptoms? Circle #

1	2	3	4	5	6	7	8	9	10

Not Frustrated Very Frustrated

Do you currently have any problems with bowel function? Fecal Incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications: Yes No

BHRT Checklist for Women

Name: _____ **Date:** _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow **The Female Pelvic Health Center** to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving **The Female Pelvic Health Center** permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

THE FEMALE PELVIC HEALTH CENTER

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how The Female Pelvic Health Centre may use and disclose protected health information (PHI) about you. The Notice contains a Patients' Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing the form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operation.

The patient understands that:

- PHI may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this notice.
- The Practice reserves their right to change the Notice of Privacy Policies
- The patient has the right to restrict the use of their PHI, but the Practice does not have the agree to those restrictions.

I give permission for The Female Pelvic Health Center to:

_____ Leave a message regarding an appointment at your designates phone number.
(Note: this is only an automated reminder of your appointment. No clinical information will be released).

_____ Share medical information with:

Name: _____
Relationship: _____

Name: _____
Relationship: _____

I assume responsibility to inform The Female Pelvic Health Center of any changes in the above information.

Print Patient's Name	Date:
Signature	Relationship to patient if other than patient
Witness:	

Revised 1/22/19

THE FEMALE PELVIC HEALTH CENTER

CONSENT FOR TREATMENT: The undersigned grants authorization to the physicians, associates, and staff at The Female Pelvic Health Center for such treatment and procedures that may be necessary for the patient herein named in accordance with the judgment of the physician. The undersigned acknowledges that no guarantees have been made as to the results of treatments or examinations in the office, or otherwise.

I realize that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION: The undersigned hereby authorizes and requests the physicians, associates, and staff of The Female Pelvic Health Center to furnish and release upon written request to all insurance companies or their representatives insuring the patient named, to The Female Pelvic Health Center and to any specific person herein named below, any and all information with respect to the patient herein named including, but not limited to, the case history, examination, prognosis, treatment medication, x-rays or surgery. Billing agencies which provide specialized services, routinely will receive information necessary for billing purposes. Medical records may also be used for educational or research purposes with the patient protected. Authorization is hereby given to physicians, associates, and staff at The Female Pelvic Health Center to release patient's name, age, sex, and nature of admission and general condition.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: The undersigned understands and hereby releases physicians, associates, and staff at The Female Pelvic Health Center from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in his possession in the office or hospital.

PAYMENT GUARANTEE: The undersigned hereby guarantees payment of all fees and charges incurred by patient for services that may not be covered under the insurance plan of the insured. In the event that the undersigned fails to make payment as provided herein or agree to alternative payment arrangements deemed satisfactory by The Female Pelvic Health Center, affirmative collection measures will be initiated. The undersigned agrees to pay all costs of collections, including twenty-five (25%) percent of the unpaid balance as a reasonable attorney's fee in the event that such indebtedness is turned over to any attorney for collection.

ASSIGNMENT OF BENEFITS: I request payment of authorized benefits to The Female Pelvic Health Center for all services rendered. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents, any information needed to determine these benefits or benefits for related services.

The undersigned certifies that (s)he has read the forgoing, that it has been fully explained and that (s)he understands its contents, and hereby agrees to all terms and conditions set forth in the above paragraphs set forth and acknowledges the receipt of a copy if requested.

_____ _____

Patient Signature Date of Signature

_____ _____

Signature of Patient Agent or Representative Relationship to Patient

_____

Witness Signature

THE FEMALE PELVIC HEALTH CENTER FINANCIAL POLICY

Thank you for choosing The Female Pelvic Health Center as your healthcare provider. Please take a moment to read our financial policy

While we participate in many health plans, there are some in which we are non-participating. Please be aware that most health plans do include out-of-network benefits that will cover a significant portion of the services rendered. If we do not participate in your plan, a representative from our billing department will be glad to review your financial responsibility.

***Please allow for a minimum of an hour when planning for your new patient appointment.**

Insurance Policy

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. You are ultimately responsible for payment to our doctors for provided services. I agree to any collection fees incurred due to any overdue balances on my account.

We will gladly process your claim, but we request your estimated portion to be paid in full at the time of service. If your insurance company has not paid your account in full within 60 days, you will have 30 days to arrange payment of the balance due

If you are a member of a managed care plan in which we are a participating provider, please understand we require payment of co-pays and deductibles at the time of service.

Patient Initials: _____

Referrals

If your health plan requires a referral, we cannot provide services to you without it. It is **YOUR RESPONSIBILITY** to contact your primary care physician and request a referral. Your primary care physician may be able to forward the referral to us electronically.

IF WE HAVE NOT RECEIVED YOUR **REFERRAL BY NOON THE DAY BEFORE YOUR APPOINTMENT**, THE APPOINTMENT WILL BE RESCHEDULED & YOU WILL BE CHARGED A NO SHOW FEE

Patient Initials: _____

Appointment Cancellation Policy

If you are unable to keep your appointment, kindly give us 48 business hours' notice. Your appointment time can then be made available to a patient on our waitlist. If notice of cancellation is not received, you will be charged as follows:

New patient: $250 **Established patient visit: $50** **Office Testing/Procedure: $250**

*If you have **cancelled the same appointment twice or miss two appointments without 48-hour notice**, you will no longer be able to schedule appointments with our practice.

* If you **DO NOT SHOW** for your **New Patient Appointment**, Your appointment will NOT be Rescheduled and you will not be able to be seen in our office due to the limited availability of these appointments.

Patient Initials _____

THE FEMALE PELVIC HEALTH CENTER FINANCIAL POLICY

Medical Records Fees

According to the PA Department of Health we charge a per page fee for request for production of medical charts or records per the health.pa.gov website including charges for postage, shipping, and delivery when applicable.

Patient Initials: _____

Medicare Authorization and Assignment

We do accept assignment of benefits; however, we are legally required to collect your deductible and 20% coinsurance at the time of service unless you have a supplemental insurance.

I request that payment of authorized Medicare benefits be made on my behalf to the service provider for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits, if any, otherwise payable to me under the terms of my private, group employers' coverage or Medigap insurance. I hereby authorize that photocopies of the form be treated as originals.

Patient Signature: _____

Commercial Insurance Authorization and Assignment

I request that payment of authorized insurance benefits be made on my behalf to the service provider for any services furnished to me. 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 or the benefits payable to related services. I hereby authorize payment directly to the service provider for the medical benefits, if any, otherwise payable to me under the terms of my private, group employers' coverage or Medigap insurance. I hereby authorize the service provider to release any medical information necessary to process my claim. I hereby authorize that photocopies of the form be treated as originals.

Patient Signature: _____

PLEASE SIGN BELOW ACKNOWLEDGING THAT YOU FULLY UNDERSTAND OUR FINANCIAL POLICY.

We accept Cash and Credit Cards for all Payments
We do not accept Checks

Patient Signature: _____ **Date:** _____

Revised 05/10/2021 *This Financial Policy is subject to change without advance notice*