

PATIENT REGISTRATION



Email Address _____

PRIMARY CARE PHYSICIAN _____

PHARMACY _____ PHARMACY PHONE #: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ DOB ____/____/____
Social Security # _____ Marital Status _____ Circle One Single Divorced
Driver's License # _____ Married Widowed Separated
Address _____ City _____ State _____ Zip _____
Home Phone # (____) _____ Work Phone # (____) _____ Cell Phone # (____) _____ Code _____

PATIENT CONTACT INFORMATION

Central Florida Urogynecology and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account. Please circle if EMERGENCY CONTACT ONLY.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand authorizing the release of this information is voluntary and does not affect my access to treatment. I can refuse to make authorization. I understand this authorization will remain in effect until I revoke it by completing a new form. I understand if this information is shared with these individuals above, that they may disclose my protected health information to other individuals. I have indicated my agreement with this authorization by signing below.

REFERRAL INFORMATION

Referred by Doctor _____ Relative _____ Friend _____ Other _____

INSURANCE INFORMATION

Primary Insurance _____
Contract or Policy # _____ If Medicare, Do you have part B Yes ____ or No ____
Group # _____ Does your Insurance require a referral? Yes ____ or No ____ How much is your Co-Pay? _____

Other Insurance: Name _____ Contract or Policy # _____ Group # _____

Insured: Name _____ Address: _____ City _____ State _____ Zip code _____

Relationship: Self ____ Child ____
Phone # (____) _____ to Insured : Spouse ____ Other ____ DOB ____/____/____

Insured: Social Security # _____

I accept full responsibility for all charges for services rendered by Central Florida Urogynecology. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of medical information necessary for completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Central Florida Urogynecology. I understand any balance left after insurance has settled claim is my responsibility. I agree to promptly pay any outstanding balance. I have read all of the information on this form and agree to these policies.

Patient's or Authorized Representative's Signature _____ Date _____



Medical History Questionnaire

Name: _____

Date: _____

Reason for today's visit?: _____

Are you in any pain?: Yes/No

If yes, how strong? : (none) 1 2 3 4 5 6 7 8 9 10 (worst ever) Where?: _____

How long have you had this issue?: _____

Do you wear pads?: Yes/No How many in a day?: _____ What type?: _____

Any allergies to medications?: _____

Current Medications: _____

Surgeries and Dates: _____

Medical Conditions? (please check before all that apply):

- | | | | |
|----------------------|---------------------------|-----------------------|-----------------|
| Abnormal PAP | COPD | Epilepsy | Hypertension |
| Anemia | Crohn's Disease | Gall Bladder Problems | Hyperthyroidism |
| Anxiety | CVA | Glaucoma | Hypothyroidism |
| Arrhythmias | Degenerative Disc Disease | Gout | IBS |
| Asthma | Depression | Hay Fever | Jaundice |
| Bipolar | Diabetes | Hearing Loss | Kidney Disease |
| CAD | Diverticulosis | Heart Attack | Liver Disease |
| Cancer | Eating Disorder | Hepatitis | Lung Disease |
| CHF | Endometriosis | Hyperlipidemia | Migraines |
| Obesity | Osteoporosis | Pancreatitis | Pneumonia |
| Rheumatoid Arthritis | Seizures | Sickle Cell Anemia | Sleep Apnea |
| Tuberculosis | Ulcerative Colitis | Other: _____ | |

Number of Pregnancies?: _____ Number of Births?: _____

Pharmacy: _____ Phone: _____

Height: _____ Weight: _____



FIRST VISIT QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

1. Do you leak urine when you cough, sneeze or laugh? Yes/No
2. Do you regularly have a strong urge to urinate, such that if you do not reach the bathroom quickly you feel you will leak? Yes/No
3. If yes, do you leak before reaching the bathroom? Yes/No
4. How many times do you get up to urinate during the night? _____
5. Have you wet your bed as an adult? Yes/No How often? _____
6. How often do you leak? ___ day/week/month/not sure
7. Do you leak during or after sexual intercourse? Yes/No/NA
8. Do you wear a pad because you are leaking? Yes/No
If so, how many do you wear per day? _____ What type? _____
9. Do you have pain when you urinate? Yes/No
10. Have you had any urinary infections in the last year? Yes/No
11. Do you have blood in your urine? Yes/No
12. Do you find it hard to start urinating? Yes/No
13. Do you have a slow urinary stream or have to strain to start urinating? Yes/No
14. After you urinate, do you feel your bladder is still full? Yes/No
15. Do you have glaucoma? Yes/No
16. Do you have a pacemaker or any metal in your body? Yes/No
17. Do you lose stool involuntarily? Yes/No
18. Do you have problems evacuating a bowel movement? Yes/No
19. Have you ever tried any medication for your bladder problem? Yes/No
If yes, please list what you have tried and if it offered any relief:

20. Has your incontinence greatly impacted your life? Yes/No
If yes, how? How does it interfere with your life?

Central Florida Urogynecology

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL RESPONSIBILITY

As your health care provider, we create a record of the care and services you receive at this office. We need this record to provide to you quality care and to comply with certain legal requirements. We are required by federal and state laws to maintain the privacy of your health information. We want you to be aware of our privacy practices that are described in this notice while it is in effect. This notice takes effect March 9, 2010, and will remain in effect until a revised notice is issued. We reserve the right to change the terms of our notice and to make new provisions effective for all personal health information we maintain, even if created or received prior to the effective date of the revision or amendment.

USES/DISCLOSURES OF HEALTH INFORMATION WITHOUT A SPECIFIC AUTHORIZATION

1. To You: We must disclose your health information to you, as described in the Individual Rights section of this notice.
2. For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose your health information to a doctor, nurse, hospital, surgery center, pharmacist, or other medical personnel who are involved in your care. In addition, we disclose the information to your insurance provider to get approval for treatment when necessary.
3. For Payment: We may disclose your health information to your insurance providers in order to get payment on claims for services provided to you. We also reserve the right to disclose some of your personal information collection agencies when necessary to collect payment.
4. For Health Care Operators: We make uses and disclosures of your health in our day to day operations as a health care provider. For example, your health information will be scanned into your electronic chart by medical staff. We do, however, take every reasonable precaution to ensure the privacy of your health information.
5. When Required by Law: We may use or disclose your health information we are required to do so by law. For example, we are required to report abuse, neglect, domestic violence and certain medical diagnoses to the appropriate agencies and sometimes adverse reactions to treatments must be reported to the FDA.
6. For Proceedings: We may disclose your health information in response to a subpoena, discovery request, or other lawful process. Under certain circumstances, such as court order, warrant or grand jury subpoena, we may disclose your medical records to law enforcement officials.
7. To Family and Friends: With your authorization, we may disclose your health information to your family, friends or others. However, if you are unable to authorize such disclosure, but emergency or similar circumstances indicate that disclosure would be in your best interest, we may disclose your health information to family, friends or others to the extent necessary to help with your health care.

USES/DISCLOSURES OF HEALTH INFORMATION REQUIRING AUTHORIZATION

Any use or disclosure of your health information, other than for the purposes listed above, requires authorization by you. You may give us written authorization to use or disclose your information to anyone for any purpose. However, we are not responsible for and cannot ensure the confidentiality of your health information once it has been disclosed to third parties. If you give us authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

YOUR INDIVIDUAL RIGHTS

1. Access: With limited exception, you have the right to review in person or obtain copies of your health information. You must make a request in writing. We will make every effort to respond to your request in a timely manner; however, the law allows us thirty days. We reserve the right to impose reasonable costs associated with making these copies as permitted by law.
2. Amendment: You have the right to request that we amend your health information that we have on file. Please be aware that we can only amend the health information if it was created by us. Your request must be in writing, and it must explain why the information should be amended. We have the right to refuse your request. If we deny your request, we will provide you with a written explanation. You may respond with a statement or disagreement to be appended to the information you wanted amended. If we accept your request, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the amendment in any future disclosures.
3. Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, or health care operations since March 9, 2010. Upon written request, we will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your health information, a description of the health information we disclosed, and the purpose of the disclosure.
4. Restriction Requirements: You have the right to request that we place certain additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement. However, if you are in need of emergency treatment, we may use or disclose that information to a health care provider in order to facilitate the provision of emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf.
5. Confidential Communication: You have the right to request that we communicate with you in confidence about your health information at an alternative address or telephone number. Again, this request must be in writing. We are required to accommodate your request if it is reasonable, specifies the alternative address or telephone number, and allows us to conduct necessary treatment, payment and health care options.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns about this Notice of Privacy Practices, you may ask to speak to our Privacy Officer.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding your health information, you may register a complaint with our Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to protect the privacy of your information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I, _____, attest that I have read the above information and understand all of its contents.

Signature: _____ Date: _____

Person authorized to disclose health information to:

Relationship: _____