Pelvic Health Specialists

Patient Information

Last Name | First Name | MI | Preferred or Nickname | Maiden Name

Date of Birth | Age | SSN | Marital Status

Address | City | State | Zip

Race: African American American Indian Caucasian Asian Pacific Islander Other Decline to Answer

Ethnicity: Hispanic NonHispanic Decline to Answer Unknown

Home Phone | Work Phone | Cell Phone

E-Mail

Preferred method of contact: Phone Home/Work/Cell Email Text

Referring Provider | Primary Care Provider

Preferred Pharmacy: _____ City: _____

Primary Insurance: _____ Plan: _____

Policy ID: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

Secondary Insurance: _____ Plan: _____

Policy ID: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

Responsible Party: _____ Relationship to Patient: _____

Address: _____ City, State, Zip: _____

Patient Signature: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Pelvic Health Specialists

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Your health information is important to you and also important to this office. Your health information is recorded in many ways. All of this information is subject to protection to certain state and federal laws from inappropriate release of others. The privacy practices that we follow to protect your health information are contained in our "Notice of Privacy Practices". The "Notice of Privacy Practices" explains in detail how medical information about you may be used and disclosed and how you can obtain access to this information. It also explains your health information rights and the responsibilities of this office when it comes to your health information. We are required to provide to you a copy of our "Notice of Privacy Practices" and obtain your signature stating that you have been offered a copy of the "Notice of Privacy Practices". By signing below I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature of patient/guardian Date

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship:_____

Home Phone:_____ Work phone:_____ Cell phone:_____

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow Pelvic Health Specialists to disclose the following protected health information: Appointment Date and Times, Test Results, Account information, Other related health information. *This permission will remain in effect until cancelled, in writing, by the patient.*

To the following people:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT

I request that payment of authorized Medicare/other insurance company benefits be made either to me or in my behalf to Pelvic Health Specialists. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or Intermediaries or carriers of any information needed for this or a related Medicare claim/other insurance company claim, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider, at the time of service, of any other party who may be responsible for paying my treatment. (Section 1128 B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.). **I authorize Pelvic Health Specialists to administer diagnostic and medical procedures as may be necessary for proper health care and to release my medical records to my referring physician and/or specialty physician as deemed necessary.** ***I understand that my insurance may not cover all of my incurred charges and I accept full financial responsibility for any remaining balance.***

_____ _____

Signature of Patient/Guardian Date

Pelvic Health Specialists

Name:_____

Todays Date:_____

General
Loss of appetite
Fever
Chills
Fatigue

Eyes
Recent change in vision

Head
Headaches
Dizziness
Vertigo-loss of balance

Ears
Decrease hearing
Earache/pain
Ringing in ears

Nose/Sinus
Sinus or face pain
Nose bleeds
Nasal discharge

Allergy/Immune
Seasonal allergies
Frequent illness

Psychiatric
Anxiety
Depression
Anger/Impulsiveness
Difficulty sleeping

Musculoskeletal
Joint pain
Limitation of Movement
Muscular weakness

Heme-Lymph
Easy bruising
Easy bleeding
Clotting disorders
Enlarged lymph nodes

GI
Nausea/Vomiting
Heartburn
Bloating
Abdominal pain
Diarrhea
Constipation
Fecal Incontinence
Gas Incontinence
Difficulty passing stools

Breast
Nipple discharge
Breast tenderness
skin changes on breast
Breast lumps

Respiratory
Chronic cough
shortness of breath at rest
Sleep apnea

Gynecologic
Vaginal discharge
Postmenopausal vaginal bleeding
Pain with sex
Bleeding with/after sex
Painful menstrual cycles
Irregular menstrual cycles
heavy menstrual cycles
Vaginal dryness
Pelvic pressure
Genital sores
Pelvic pain

Urinary
Urinary urgency
Urinary frequency
Blood in urine
Leaking urine
Painful urination
Difficulty starting stream
Bladder falling out
Incomplete bladder emptying
Up at night to urinate more than 2 times

Cardiovascular
Heart racing
Shortness of breath
Chest pain

Neurologic
Memory issues
Numbness/Tingling
Generalized weakness

Skin
Acne
Change in hair growth
New/change in skin lesion

Risk Assessment for Hereditary Cancer Syndromes

Patient Name:_____Date of Birth: _____ Date _____ Physician_____

Our clinic is dedicated to improving your quality of care, committed to your health, and helping with cancer prevention. To best serve you, we need a detailed personal and family cancer history.

SEE EXAMPLE!!!!!!!!! Please consider the following Family Members when completing this form: (Blood Relatives Only)

- Mother, Father, Sister, Brother, Children: **(1st degree relatives)**
- Aunt, Uncle, Grandmother, Grandfather, Grandchild, Niece, Nephew, Half Siblings: **(2nd degree relatives)**
- Cousins, Great Grandparent, Great Aunt, Great Uncle: **(3rd degree relatives)**

		BREAST AND OVARIAN CANCER (BRACAnalysis)	SELF	FAMILY MEMBER	
				MOTHER'S SIDE/AGE of diagnosis	FATHER'S SIDE/AGE of diagnosis
Y	N	**EXAMPLE: Breast Cancer at age 45 or younger**		**Aunt/42**	
Y	N	Breast cancer younger than 50 (in self, 1st, 2nd degree family members)			
Y	N	Ovarian cancer at any age (in self, 1st, 2nd degree family members)			
Y	N	**Two breast cancers on the same side of the family with one being diagnosed at or under the age of 50, or bilateral breast cancer at ANY age** (in self, 1st, 2nd, or 3rd degree family members)			
Y	N	Three or more of the following cancers at any age on the same side of the family: breast, ovarian, pancreatic, prostate (in self, 1st, 2nd, or 3rd degree family members)			
Y	N	Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2) (in self, 1st, or 2nd degree family members)			
Y	N	Male breast cancer at any age (in self, 1st, 2nd, degree family members)			
Y	N	Breast or ovarian or pancreatic cancer at any age with Ashkenazi Jewish ancestry. (in self, 1st, 2nd, 3rd degree family members)			
Y	N	A family member with a known hereditary cancer mutation (BRCA, PALB2, CHEK2, Lynch, ATM, etc) (in self, 1st, 2nd, or 3rd degree family members)			
		COLON AND UTERINE CANCER (COLARIS)	**SELF**	**FAMILY MEMBER**	
				MOTHER'S SIDE/AGE of diagnosis	**FATHER'S SIDE/AGE of diagnosis**
Y	N	Uterine (endometrial) cancer before age 50 (in self, 1st, or 2nd, degree family members)			
Y	N	Colon cancer before age 50 (in self, 1st, or 2nd, degree family members)			
Y	N	2 or more of the following cancers (**Colon, uterine, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas**). (One of the cancers diagnosed before the age of 50 and one must be colon, rectal or uterine cancer) (in self, 1st, or 2nd, 3rd degree family members)			
Y	N	3 or more of the following cancers at any age (**Colon, uterine, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas**). (One must be colon, rectal or uterine cancer). (in self, 1st, or 2nd, 3rd degree family members)			
Y	N	A family member with a known Lynch Syndrome mutation (in self, 1st, or 2nd, 3rd degree family members)			

Pelvic Health Specialists

1112 W 6th St, Ste 212 Lawrence, KS 66044

FINANCIAL POLICIES

Thank you for choosing Pelvic Health Specialists as a part of your health care. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship.

Co-pays

The patient is expected to present an insurance card at each visit, even if we have the information on file. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full at the time of service for the initial office visit and any planned procedures. A payment plan will be required for any services provided at the time of service that were not discussed prior to the visit..

Surgery and in-office procedures

Pre-payment for all estimated patient out of pocket costs including deductibles and co-insurances is required **prior** to the time of service unless other arrangements have been agreed upon. Failure to pre-pay balance in full or to comply with terms of any payment arrangements could result in postponement or cancelation of your procedure. Any overpayments will be refunded promptly.

Surgery Cancellations

If you need to cancel a surgical procedure you must contact our office as soon as you are aware of the scheduling conflict or other issue. We make every effort to answer our phones however we are often in rooms with patients, it is important that you leave a message so that we may return your call. Cancellations less than 7 business days from the scheduled date of surgery are subject to a $200.00 non-refundable cancellation fee.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors. A minor is a person under the age of 17, regardless of any arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Outstanding Balance Policy

It is our office policy that all accounts with a balance due will be sent three statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, we reserve the right to send to your account to a collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including any attorney fees and court costs. You may be placed on a pre-pay, cash only status for any further services.

Returned Checks

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a pre-pay cash only basis following any returned check.

_____

(Print Name)

_____ _____

(Signature) (Date)

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.