modern | urogynecology

Patient Information

Patient's Full Name: _____
Last First Middle

Age: ___ Date of Birth: _____ Social Security No.: ___-___-___ Marital Status: M / S / D / W

Patient's Address: _____
City, State, Zip

Phone Number: _____ Work Number: _____ Home Number: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Who referred you to our office? _____ Phone Number: _____

Who is your Primary Care Physician? _____ Phone Number: _____

Are there any other physicians that you would like us to keep informed of your care? If so, please list their name(s) and phone number(s). _____
_____
_____

Preferred Pharmacy: _____
Name Address/Location Phone Number

Insurance Information: (please provide the office staff with your insurance card upon arrival)

Primary Insurance: _____ Phone Number: _____
Subscriber/Member ID: _____ Group Number: _____
Policy Holder: _____ Date of Birth: _____

Secondary Insurance: _____ Phone Number: _____
Subscriber/Member ID: _____ Group Number: _____
Policy Holder: _____ Date of Birth: _____

All professional services rendered are charges to the patient. Necessary forms will be completed to expedite insurance carrier payment. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment

I hereby authorize this medical facility to furnish information to my insurance carrier concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Date: ___/___/___ Signature: _____

modern | urogynecology

OFFICE POLICIES

Thank you for choosing Modern UroGynecology for your medical care. Below you will find our office policies. Please read over them and should you have any questions or concerns, please feel free to contact us during normal business hours. To better serve the Metroplex, we have a variety of office locations to suit most patient's needs. The clinic hours at those locations may vary – however, our business hours are from 8am-5pm with a break for lunch from 12pm-1pm.

GENERAL OFFICE POLICIES:

Appointments: Patients are seen by appointment only. If you anticipate or realize you will be more than 15 minutes late, please contact the office to notify the staff. You may be asked to re-schedule.

If time allows, appointment reminder calls are made a day or two before scheduled appointments.
We do request that if you must cancel your appointment, please do so within 24 hours of your scheduled appointment date and time.
_____ **(Please initial) A $25 cancellation fee will be assessed for any New Patient or Follow Up appointments not cancelled within the 24 hour timeframe.**
_____**(Please initial) A $50 cancellation fee will be assessed for any Urodynamic Study not cancelled within the 24 hour timeframe.**

FINANCIAL POLICIES:

Referrals: Sometimes your insurance requires a referral to see a specialist, it is necessary for you to notify your primary care physician of this. Please verify that your primary care physician will obtain the referral authorization and it is beneficial that you receive a copy of any documentation of that authorization. We can schedule the patient without documentation of the referral authorization, but the physician will not be able to treat the patient without this documentation. Most primary care physician offices require at least 48 hours (or more) to process the referral authorization. Please have your PCP fax the referral to our office (469)440-7400.

Insurance Cards: Please notify the office staff if your insurance has changed, or if you have received a new insurance card. It is important to ensure we have the correct identification numbers and filing information.

Benefits: Insurance benefits can be very confusing. Each patient's policy differs. Our office staff will do their best to help you understand what your insurance covers, however, ultimately, it is your responsibility to be familiar with your benefits, including limitations and exclusions, as you, the patient, are responsible for payment. If you have any questions regarding any of this, including covered services, deductibles, maximum benefits, please contact the insurance administrator of your employer or your insurance company.

Co-Pays: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address multiple problems during a physical exam or at the same time you have a procedure scheduled.
There will be a $50 fee for any returned check.

HMO/POS: You are required to be directed/referred by your **P**rimary **C**are **P**hysician (PCP) that you have selected or been assigned to by your insurance company before your appointment with Dr. Patel. If you have not done this, your insurance will not pay for your visit and you would be responsible for payment in full.

modern | urogynecology

Office Policies continued…….

Terminating Relationship: Unfortunately, it is sometimes necessary to terminate the patient/physician relationship. Our office will provide written notice of the termination and comply with regulations stipulated by the Texas Medical Board.

Insurance payments: We will sometimes ask your assistance to get the insurance company to pay the submitted charges. If they request some information from you, it is extremely important that you get them the information they request in a prompt manner. Always keep a copy of what you send them, along with the person's name to send it to. Please follow up with that person within 24 hours to verify that they have received the information you sent and will be processing your claims. Ultimately, it is your responsibility for payment of the services provided.

Responsible Party: This is the patient or their guardian for whom is responsible for their medical bills. Please make sure we have current and up to date responsibility party information, such as name, address and telephone number.

Self-Pay: Payment is required in full at the time of service. Self-pay prices vary depending on services rendered. Please speak with the office staff regarding self-pay options.

Additional Fees: If your employer requires any FMLA, Short / Long Term Disability forms or if you have any AFLAC or additional forms that need to be completed for your time off because of surgery, we require those forms to be submitted to our office within ten (10) days of your surgery date. There is a $25 fee for *each* form submitted to be completed. This includes forms for family members and spouses that are taking time off to care for you as well.

TREATMENT POLICIES:

Your treatment will be based on medical necessity. Some procedures and labs may not be covered under your particular insurance plan. It is not our responsibility to verify that everything is covered before treatment is provided. It is recommended that if you are referred to an outside lab or imaging facility, that you contact your insurance provider to find out who has the best pricing and who is contracted with your policy. We will always do our best to accommodate these needs.

Medication: We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a very high co-pay, we would need to be provided with alternatives that are financially acceptable to you. In this case, you would need to contact your insurance / pharmaceutical provider and they will notify you which prescription would be best comparable and cost effective.

Refills: Please plan ahead for your prescription refills. If your prescription says no refills, please call your pharmacy. They will process an electronic or fax a refill request to us. Please allow up to 48 hours to process the authorization request, we ask that you plan accordingly.

_____ _____

Patient Signature Date Signed

_____

Print Name

modern | urogynecology

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected heal information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

__ Home Telephone Number: _____
- __ Leave message w/detailed information
- __ Leave message w/call-back number only

__ Written Communication
- __ Mail to my home address
- __ Mail to my work/office address
- __ Fax to this number: _____

__ Work Telephone Number: _____
- __ Leave message w/detailed information
- __ Leave message w/call-back number only

Other: _____
_____
_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Please note: Uses and disclosures for patient treatment records, payment information, and/or healthcare operations may be permitted without prior consent in an emergency.

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Name Date of Birth

modern | urogynecology

Consent for Treatment and Payment Agreement

I hereby authorize Amit I. Patel, MD to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of Amit I. Patel, MD may refuse to treat me. I authorize the providers to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the providers and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered valid as original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and/or percentage which will leave you liable for any additional charges incurred. I have fully read and understand the above payment policy. I agree to forward Amit I. Patel, MD all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Lifetime Authorization

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or I request this authorization also apply to all other insurance.

Patient Signature: _____ Date: _____

Release of Medical Information

Please let us know the names of whom we may release health information to or may be allowed to enter the exam room during discussion regarding heal information. I understand that I may request individuals to leave the room at any time.

Name of Person who is authorized:	***Release info***	***Allowed in exam room***
_____	Yes / No	Yes / No
_____	Yes / No	Yes / No
_____	Yes / No	Yes / No
_____	Yes / No	Yes / No

What Information may we release to the above named recipient:

__ All Personal Health Information __ Billing information __ Office Notes __ Mental Health records
__ Labs/Diagnostic test results __ Prescriptions __ Appointment information

This authorization for release of information expires: _____

Patient Name: _____ **Patient Date of Birth:** _____

Patient Signature: _____ **Date:** _____

modern | urogynecology

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____
Printed Name

Previous Name: _____ Social Security #: _____
(Maiden Name)

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Modern Urogynecology / Amit I. Patel, MD FACOG
Address: 3822 Bower Ave. (mailing/administrative) Dallas, TX 75219

This request and authorization applies to:

__ Healthcare information relating to the following treatment, condition or dates: _____
_____
_____

__ All healthcare information

__ Other: _____

_____ _____
Patient Signature Date Signed

PLEASE FAX RECORDS TO: 469 – 440 – 7400

Thank you!

modern | urogynecology

Medical and Surgical History Intake Form

Patient Name:	Date of Birth:

Medical History

Medical Problem	When Diagnosed?	Medication(s) for this?
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No

Medication List (please use a separate sheet of paper if needed)

Medication (rx name)	Dosage (mg, mcg)	Route (ex: by mouth)	Frequency (how often taken)	Indication (why do you take it)

Allergies ___ NKDA

Medication	Reaction
Latex Allergy? Yes No	

Surgical History (use a separate sheet of paper if needed)

Procedure	When? (Age or Year only)

Social History

Do you drink alcohol? Yes No	How much / often?
Do you smoke? Yes No	How many packs /day?
When did you quit smoking? (year)	How long were you a smoker? (years)
Ilicit drugs? (marijuana, meth, cocaine? Yes No	Please specify:
Do you work? Yes No	Occupation:
Do you have tattoos? Yes No	

Obstetric History

How many pregnancies?	How many births?
How many were Full Term?	How many were Pre Term?
What type of births were they?	# Vaginal? # C-Section?
How many miscarriages / terminations?	
Were forceps used in vaginal delivery? Yes No	If yes, please indicate the # of times:
Size of your largest vaginal delivery:	LBS OZ
Any tears/episiotomy involving the rectum or muscle around the rectum?	Yes No

Gynecologic History and Health Maintenance History

Last Pap Smear / Annual GYN exam:	Year: Normal? Yes No
History of abnormal Paps? Yes No	If so, when? (year) How many?
History of treatment for abnormal paps?	Yes No When?
----------Treatments:	
History of sexually transmitted infections? (ex Gonorrhea, Chlamydia, P.I.D.) Yes No	When were you treated?
Sexual orientation?	Straight Gay Bisexual
Frequency of sexual activity?	
Last mammogram?	Year: Normal? Yes No
Last colonoscopy?	Year: Normal? Yes No
Last bone density screening?	Year: Normal? Yes No

Family History

Medical Issue	Affected Family Member	Age of Diagnosis
Breast Cancer		
Uterine Cancer		
Ovarian Cancer		
Colon Cancer		
Bleeding Disorders		
Blood Clotting Disorders		
Other		

Anesthesia History

Reactions to anesthesia?	Yes No	Reaction:	Medication:
History of blood transfusion?	Yes No	When:	Why:
Reaction to transfusion?	Yes No	Reaction:	How treated: