PATIENT REGISTRATION FORM

EMAIL:_____

First Name: _____Last Name: _____ MI: _____ DOB: _____

Soc Sec # (For Billing Purposes): _____ Name you go by: _____

Address: _____City: _____ State: _____Zip: _____

Home #: _____ Cell #: _____ Work #: _____

PLEASE CIRCLE THE BEST CONTACT NUMBER FOR YOU

Occupation: _____ Employer: _____ Marital Status: Single Married Divorced Widowed

Primary Care Physicians Name: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Pharmacy Name/Cross Streets: _____ Pharmacy Phone #: _____

REFERRED BY

We are so glad that you have chosen AZ Urogynecology for your female pelvic health needs. Please let us know how you heard about us... Physician ____ Web-site ____ News Article ____ Referral____ Other ____

If patient, whom: _____ or DR: _____

PRIMARY INSURANCE INFORMATION

Insurance Co: _____Group #: _____ ID#: _____

Primary Subscribers Name: _____ DOB: _____ SOC #: _____

Relationship to patient: Self Spouse Child Effective Date: _____ Phone #: _____

Deductible: _____Co-Pay: _____ Spouse Employer (If Policy Holder): _____

SECONDARY INSURANCE INFORMATION

Insurance Co: _____ Group #: _____ ID#: _____

Primary Subscribers Name: _____ DOB: _____ SOC #: _____

Relationship to patient: Self Spouse Child Effective Date: _____ Phone #: _____

Deductible: _____ Co-Pay: _____ Spouse Employer (If Policy Holder): _____

CONSENT/AUTHORIZATION

I consent to and authorize treatment for myself/the above named patient. I further authorize any and all information requested by insurance companies and health professionals participating in my care. If there are healthcare providers you DO NOT want us to provide information to please provide the request in writing so it may be placed in your records.

Signed: _____ Date: _____

AZ UROGYNECOLOGY & PELVIC HEALTH CENTER
FINANCIAL POLICY GUIDELINES

WELCOME

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. In order to reduce potential confusion, we have adopted the following Financial Policy Guidelines. Please read and sign it prior to the commencement of any treatment.

APPOINTMENTS

To schedule an appointment, please call our office at (480) 889-2654. We strive to provide the best possible service available to all of our patients. If you are unable to keep an appointment, please call at least 24 hours in advance so that we can schedule another patient who is waiting in that time slot. Many of our patients have urgent needs, so we use appointment cancellations to accommodate their special needs. **Patients with recurrent missed appointments or short-notice cancellations will be charged a $25.00 fee for each missed appointment.** This fee is not billed to your insurance company; it is solely your responsibility. If you call for an urgent appointment, we will make our best effort to accommodate your needs. **Due to the complex surgery scheduling process, if you cancel your surgery within a week of surgery there will be a $200.00 cancellation fee.**

RECORDS

OUR OFFICE POLICY REQUIRES A $25 CHARGE FOR ANY MEDICAL RECORDS OBTAINED BY PATIENTS. IF A PATIENT WANTS RECORDS TO GO TO ANOTHER PHYSICIAN THERE IS NO CHARGE. IF A PATIENT WANTS RECORDS FOR AN ONGOING LEGAL CASE, PLEASE HAVE YOUR ATTORNEY REQUEST THE RECORDS.

INSURANCE

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. All health plans are not the same and they do not always cover the same services. In the event your health plan determines a service is "not covered", you will be responsible for the complete charge. This office is not responsible for disputing your insurance company's decision regarding coverage.

We will do our best to prior authorize any and all tests and procedures prior to them being done. **We expect that you be responsible in knowing your insurance benefits, including but not limited to: deductible, and co-payment amounts as well as labs, radiology facilities and hospitals contracted with your plan.** If you have insurance coverage with a plan in which we do not participate or you have no health insurance plan, our charges for your care are due at the time of service. You may, however, bill your insurance company, even if we are not a contracted provider. Our office will provide you with the necessary paperwork to do so.

ADMINISTRATIVE

Your insurance is your responsibility! It is a courtesy to our patients, we will file claims for these plans which we have an agreement. **It is your responsibility to notify our office with current and valid insurance information.** If your insurance does not pay within a reasonable amount of time, we will look to you for payment. Any costs incurred by this office because of incorrect information provided to us will be your responsibility. Payment is due upon receipt of a statement from our office.

All monies owed including co-pays, deductibles or outstanding balances are collected at the time of service.

Administrative Fees: **$25.00 fee for NSF returned checks**
$25.00 fee for repetitive no show or late cancellations

If this account should go into default, you understand that you will be held liable for all collection fees and attorney fees incurred to collect this debt.

If this account has a credit of $25.00 or less, this money will be held on account for future visits. If you do not wish this money to be used for future visits, please notify our billing manager and request a refund.

I have read and understand the financial policy guidelines:

Patient: _____ Date: _____

AZ UROGYNECOLOGY & PELVIC HEALTH CENTER
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information, as outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand this information can be used to:

- Conduct, plan and direct my treatment and also assist with follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** has the right to change its Notice of Privacy Practices from time to time and that I may contact **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** at any time and obtain a copy of a current copy of the Notice of Privacy Practices.

I understand that I may request in writing a requisition of particular restrictions that I would like to be applied to the use and disclosure of my private information as it is used to carry out treatment, payment or healthcare options. I also understand **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** is not required to agree to my requested restrictions. However, if **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** does not agree, **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** is still bound to abide by such restrictions.

I agree that **AZ UROGYNECOLOGY & PELVIC HEALTH CENTER** may discuss my medical information and/or insurance information with;

Name: _____ Relationship: _____

Name: _____ Relationship: _____

APPOINTMENT AND CANCELLATION POLICY AND PROCEDURE

If you must reschedule or cancel your appointment due to an emergency or illness, we ask that you provide advance notice (at least one business day). Patients that call to cancel the day of their appointment or do not show are considered to have NO SHOWED. NO SHOWED appointments will be charged a fee of $25. After the third NO SHOW, all of your future appointments will be cancelled and you will need to make an appointment with the provider to re-establish a plan of care.

Patient Name: _____ Date: _____

Signature: _____ Relationship: _____

AZ UROGYNECOLOGY
& PELVIC HEALTH CENTER
MOHAMED AKL, M.D., FACOG
6632 E. BASELINE RD. SUITE 101
MESA, AZ 85206
OFFICE: 480.889.2654 FAX: 480.699.1022
WWW.AZUROGYN.COM

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ Home Ph: _____

State Zip: _____ Other Ph: _____

MAIL OR FAX THE RECORDS TO THE ADDRESS/FAX BELOW

_____

_____

_____

PHONE: _____ FAX: _____

PLEASE RELEASE MEDICAL RECORDS PERTAINING TO THE PATIENTS BLADDER AND/OR PELVIC FLOOR INCLUDING BUT NOT LIMITED TO ANY TESTING, SURGERIES AND TREATMENTS OR THERAPIES.

SPECIFIC REQUESTS: _____

Reason for requesting records: CONTINUED CARE SURGICAL CONSULT

(Circle One)

TESTING OTHER: _____

By signing this, I authorize the release of the above requested records and anything pertinent the physician feels will be beneficial in the pursuance of my overall healthcare. Including but not limited to any disclosure that may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and alcohol use, sexual history and that the records will be forwarded to the address/phone on the letterhead. I further authorize that these records may be faxed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already taken place. I hereby give my consent freely, voluntarily and without coercion or hesitation:

_____ _____

(Patient signature or parent/legal guardian if minor) (Date)

This fax is personal and privileged information intended for the named recipient only. If you have received it in error, please destroy it and call us to let us know you have received it. Thank You.

AZ UROGYNECOLOGY

BLADDER SYMPTOM INTAKE FORM

NAME:_____DOB:_____DATE:_____

SYMPTOMS	YES	NO
Do you have a leakage of urine with laughing, coughing, sneezing, or exercising? **If yes, how many times? _____ per day or _____ per week**		
Do you have leakage of urine before reaching the bathroom? **If yes, how many times? _____ per day or _____ per week**		
Do you have sudden unexpected leakage of urine?		
Did you ever see blood in the urine?		
Do you feel that you completely empty your bladder after urination?		
Do you have repeated bladder infections?		
circle any bladder medication(s) that you have tried: **Detrol LA, Ditropan, Oxybutinin, Sanctura, Enablex, Vesicare, Toviaz, Oxytrol patch, Myrbetriq or other: _____**		
Did you have anti-leakage surgical procedure (s) in the past? **If yes, please write the procedure name_____and date_____**		
Do you feel any bulge or pressure in the vagina?		
Do you have bowel leakage? **If yes, how many times? _____ per day or _____ per week**		
Did you have hysterectomy?		
How many times do you go to the bathroom to urinate along the day? _____ times/day		
How many times do you wake up during the night to urinate if any? _____ times/night		
How many kids do you have? _____ vaginal _____ c/section		
Check or circle if you have any of the following disorders (__) Diabetes, (__) Back injury, (__) Neurological disorders,		
Do you need to wear protective (___) liner or (___) Pad or (___) Diaper (check what applies to you)		

PATIENT SIGNATURE: _____ DATE:_____

PATIENT HISTORY FORM

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME: _____ FIRST NAME: _____ DOB: _____ DATE: _____

Review of Systems

Do you now or have you had problems related to the following systems:

Circle YES or NO

Constitutional Symptoms		Comments
Weight Change	Y N	
Chills/Fever	Y N	
Sleep Disorder	Y N	

Eyes		
Double Vision	Y N	
Glaucoma	Y N	
Cataracts	Y N	

Ear/Nose/Throat/Mouth		
Hearing Changes	Y N	
Sore Throat	Y N	
Sinus Problem	Y N	

Cardiovascular		
Chest Pain	Y N	
Irregular Heartbeat	Y N	
Swelling in Ankles	Y N	

Psychological		
Are you generally happy?	Y N	
Do you feel depressed?	Y N	
Do you feel anxious?	Y N	
Do you feel safe in your home?	Y N	

Endocrine		
Excessive Thirst	Y N	
Too Hot/Cold	Y N	
Tired/Fatigued	Y N	
Irregular Periods	Y N	
Heavy Bleeding	Y N	
Bleeding after Menopause	Y N	

Hematologic/Lymphatic		
Swollen Glands	Y N	
Blood Clotting Problems	Y N	
Bruising	Y N	

Allergic/Immunologic		
Hay Fever	Y N	
Drug Allergies	Y N	
Food Allergies	Y N	
Other:		

Musculoskeletal		Comments
Bone Pain	Y N	
Muscle Pain	Y N	
Joint Pain	Y N	

Integument (skin)		
Rash	Y N	
Lumps or Bumps	Y N	
Moles, Skin Tags	Y N	

Respiratory		
Wheezing	Y N	
Frequent Cough	Y N	
Shortness of Breath	Y N	

Neurological		
Tremors	Y N	
Dizzy Spells	Y N	
Numbness/Tingling	Y N	

Gastrointestinal		
Abdominal Pain	Y N	
Nausea/Vomiting	Y N	
Indigestion/Heartburn	Y N	
Constipation/Diarrhea	Y N	
Other:		

Genitourinary		
Urinary Incontinence (loss of urine)	Y N	
- Spontaneous	Y N	
- With Activity	Y N	
Urinary Frequency>8 times/day	Y N	
Painful Urination	Y N	

Sexual History		
Are you currently sexually active?	Y N	
Heterosexual or Homosexual (circle one)		
Have you ever been sexually active?	Y N	
Method of Contraception _____		
Change in sex drive	Y N	
Painful Intercourse	Y N	
Sexual Trauma	Y N	

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

MEDICAL HISTORY FORM

LAST NAME: _____ FIRST NAME: _____ DOB: _____ DATE: _____

Medical Conditions ☐ None (High Blood Pressure, Diabetes, Cancer, Heart Disease, **ETC**.)_____

_____

_____

_____

_____

Pregnancy History

Year	Sex	Complications
____	____	_____
____	____	_____
____	____	_____
____	____	_____

Surgical ☐ None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

_____

_____

_____

_____

_____

_____

Gyn/Breast/Colon History

Last Pap: _____

Last Mammo: _____

Colonoscopy: _____

Sigmoidoscopy: _____

Regular Periods? _____

Length of Periods? _____

Age at 1st Period? _____

Allergies to Medications None (If yes, explain type of reaction, i.e. hives, wheezing, upset stomach, swelling etc.)

_____

_____

Current Prescription Medicines None

Name of Drug	mg dose	#tablets	#times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Prescription Medicines (cont'd)

Name of Drug	mg dos	#tablets	#times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

	Living	Deceased	Illness	Cause of Death/Illness
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Sister (s)	☐	☐	_____	_____
Brother (s)	☐	☐	_____	_____

Other Family History:	Yes	No	Family Member		Yes	No	Family Member
Heart Disease	☐	☐	_____	Osteoporosis	☐	☐	_____
Cancer (type)	☐	☐	_____	Thyroid Problems	☐	☐	_____
Diabetes	☐	☐	_____	Endometriosis	☐	☐	_____
Alcohol Abuse	☐	☐	_____	Other	☐	☐	_____

SOCIAL HISTORY

Smoke? ☐ Yes ☐ No If yes, # of packs per day: _____ # of years: _____ When did you stop smoking? _____

Alcohol: ☐ Yes ☐ No If yes, how many drinks per week? _____

Occupation? _____

☐ Coffee- How much? _____ ☐ Tea- How Much? _____ ☐ Soda- How much? _____

Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when:

_____

Domestic Violence?

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

AZ UROGYNECOLOGY & PELVIC HEALTH CENTER
CREDIT CARD AUTHORIZATION

To Our Patients:

Welcome to our practice. AZ UROGYNECOLGY & PELVIC HEALTH CENTER continually strives to make our office as convenient and efficient as possible for the patient.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurance. **Prior to charging your credit card, AZ Urogynecology & Pelvic Health Center will call you to confirm the charges. If you do not return our calls to confirm or reschedule the charge, your card will be charged after our second message to you.**

When you receive your EOB (explanation of benefits) from your insurance company, it will state the patient responsibility amount.

As always, any and all co-pays are due and collected at the time of your visit. If you have any questions or concerns, please do not hesitate to ask to speak to our billing manager.

Thank you,

AZ UROGYNECOLOGY & PELVIC HEALTH CENTER

CIRCLE ONE: VISA MASTERCARD DISCOVER AMEX

PRINT PATIENT NAME: _____

PATIENT DOB: _____

CREDIT CARD NUMBER: _____

EXP DATE: _____

CARD HOLDERS NAME: _____

☐ **I decline this option with the acknowledgment that if payment arrangements need to be made, this agreement can be readdressed at that time.**

Signature: _____ Date: _____