Review of Systems

Do you or have you had any problems related to the following symptoms? Circle **Y**es or **N**o.
Please explain any Yes answers in space provided.

Name_____ **Date**_____

Constitutional:

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N

Eyes:

Blurred vision	Y	N
Double vision	Y	N
Cataracts	Y	N

Ears/Nose/Mouth/Throat:

Hearing Loss	Y	N
Nasal Stuffiness	Y	N
Sore Throat	Y	N

Cardiovascular:

Chest Pain	Y	N
Swollen Ankles	Y	N
Irregular Heartbeat	Y	N

Respiratory:

Shortness of Breath	Y	N
Wheezing	Y	N
Chronic Cough	Y	N

Gastrointestinal:

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Change in Bowels	Y	N

Musculoskeletal:

Chronic Back Pain	Y	N
Chronic Neck Pain	Y	N
Sore Muscles	Y	N

Integumentary/Skin:

Rash	Y	N
Persistent Itching	Y	N
Skin Cancer History	Y	N

Neurological:

Numbness	Y	N
Tingling	Y	N
Dizziness		

Hematologic:

Swollen Glands	Y	N
Abnormal Bleeding	Y	N
Transfusion History	Y	N

Genitourinary:

Incontinence	Y	N
Pain with Urination	Y	N
Blood in Urine	Y	N

Physician's Signature _____ Date _____

PATIENT ASSESSMENT and BLADDER SURVEY

Name: _____ Date: _____

Which symptoms best describe you? Check all that apply.

☐Frequent Urination- Day, Night, and/or Both
☐Sudden or Strong Urge to urinate
☐Leakage with little or no warning-Sometimes unable to make it to the bathroom in time
☐Unable to completely empty bladder- Feels like there is more even after voiding
☐Accidental leakage with physical activity like exercising, sneezing or coughing
☐Bladder or Pelvic Pain

Are you sexually active? ☐Yes ☐No
If you are sexually active do you now or have you ever had pain or symptoms during or after intercourse?
Please circle: Never Occasionally Usually Always

How long have you had any of the above symptoms?_____

Which symptom is the most bothersome to you? _____

Have you tried medications to help your bladder symptoms? ☐Yes ☐No

If yes, check the medications you have tried:

☐Detrol LA ☐Elavil ☐Oxybutynin ☐Toviaz ☐Myrbetriq
☐Ditropan XL ☐Elmiron ☐Oxytrol Patch ☐Vesicare
☐Enablex ☐Gelnique ☐Sanctura XR ☐Other _____

Have these medications helped your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

Are you still taking any of these medications? ☐Yes ☐No

If No, why have you stopped taking them?

☐Did not work as well as expected ☐Side Effects ☐Expense
☐Interaction with other taken medications ☐Other

If Side Effects or Other, please explain: _____

Behavioral Modifications Tried? _____
(i.e.- reduced fluid intake; caffeine reduction; Kegel exercises; physical therapy; lifestyle changes)

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

0	1	2	3	4	5	6	7	8	9	10

No Frustration ***CompleteFrustration***

Are you interested in learning more about additional treatment alternatives to medications?
☐Yes ☐No

Name: _____ Date:_____

Overactive Bladder Symptom Score (OABSS)

Question-Circle Score that best describes you	Response	Score
How many times do you typically urinate from waking in the morning until sleeping at night?	≤ 7 8-14 ≥ 15	0 1 2
How many times do you typically wake up to urinate from sleeping at night until waking in the morning?	0 1 2 ≥ 3	0 1 2 3
How often do you have a sudden desire to urinate, which is difficult to defer?	None < once/week ≥ one/week about once/day 2-4 times/day ≥ 5 times/day	0 1 2 3 4 5
How often do you leak urine because you cannot defer the sudden desire to urinate?	None < once/week ≥ once/week about once/day 2-4 times/day ≥ 5 times/day	0 1 2 3 4 5

Quality of life due to urinary problems:
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? Circle the number that best reflects your feeling about your urinary problem.

0	1	2	3	4	5

Pleased ***Terrible***

PATIENT INFORMATION RECORD (FEMALES)

Name:

_____

Reason (s) for visit:

_____

Past and Current Health problems:_____

_____

_

Medication (s) and Supplements: _____

_____

_

Allergies:

_____

Surgeries/Hospitalizations: _____

Last Menstrual Period _____ **Do you have regular periods?** Y N

Have you been through menopause? Y N **If so, have you had any bleeding after menopause**? Y N

Have you experienced any abnormal bleeding between periods or heavy bleeding? Y N

If so, please explain: _____

How many pregnancies have you had? _____ How many miscarriages? _____

Please list births and specify mode of delivery (vaginal or caesarian section). Please include weights of birth._____

___

Your occupation: _____ **Marital Status**

_____

Do you smoke? Y N **Have you ever smoked?** Y N **If so, when did you quit?**

_____

Do you drink alcohol? Y N **If so, how many drinks per week? _____**

Do you use any recreational drugs? Y N **If so, what type? _____**

What health conditions run in your family? Please list who has them

_____

_____

____

How many caffeinated drinks do you consume daily? _____

Language: English Spanish French Other_____

Race: White Black or African American American Indian Other_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Height:** ____ft. ___in **Weight:** _____

Preferred Pharmacy and Pharmacy Address:_____

Signature _____**Date**_____

RECEIPT OF NOTICE
OF PRIVACY PRACTICES

I have received a copy of **Adult & Pediatric Urology and Urogynocology, P.C.'s** Notice of Privacy Practices that became effective April 14, 2003.

_____ _____

Date Print Patient Name

_____

Signature

Note: If signed by someone other than the patient, we need written proof of your authority.

I, _____, give my permission to Adult & Pediatric Urology, P.C., to give any & all medical information regarding myself to the following person(s):

_____

_____

_____

_____ _____

Signature Date

For office use: A signature was not obtained because: _____

_____

_____

ADULT PEDIATRIC UROLOGY & UROGYNECOLOGY

It is the policy of Adult & Pediatric Urology and Urogynecology, P.C. to encourage our patients to arrive and receive care at their scheduled arrival time, or to give appropriate notice of cancellation to allow other patients to receive timely care.

If you are unable to make your scheduled appointment, we request that you notify us as soon as possible, but no later than 24 hours prior to your scheduled arrival time. Additionally, we request that you arrive at your scheduled arrival time.

By either not providing 24 hour notice of cancellation or choosing not to arrive without any notice to your scheduled appointment, **you will be charged a $100.00 fee for missed office visits in which an interpreter was scheduled.**

It is not our intent to assess an additional financial burden, but it is costly if you miss your appointment and do not give us adequate time to cancel the interpretation services that are provided for you.

If three (3) or more appointments are missed, Adult & Pediatric Urology and Urogynecology, P.C. reserves the right to terminate our relationship with you.

Patient Signature Date

Printed Patient Name Date

ADULT PEDIATRIC UROLOGY & UROGYNECOLOGY

10707 Pacific Street Omaha, NE 68114 Telephone: (402) 397-7989

FINANCIAL POLICY

We are extremely pleased that you have chosen Adult & Pediatric Urology, P.C. for your health care needs. This information regarding financial matters will be helpful to you in understanding our billing process. All patients must accept this FINANCIAL POLICY before receiving treatment.

1. Adult & Pediatric Urology, P.C. files insurance claims for patients as a courtesy. ***Regardless if you have an insurance plan, you still have full responsibility for payment of the bill.*** It is also the patient's responsibility to know if the physician he or she is seeing is a participating provider with his/her health plan.

2. **Co-payments** are always due at the time of service. Our contractual agreement with your carrier prevents us from waiving your required co-pay amount.

3. If you have **no insurance coverage, payment in full is due at the time of services.**

4. Payment for **elective or additional services** will be required at the time of service and will not be filed with your insurance company. This may include but is not limited to additional fees for copying of medical records or completion of FMLA/Short Term Disability paperwork.

5. We accept **CASH, MONEY ORDERS, CHECKS, VISA, MASTERCARD, CARE CREDIT and DISCOVER. You may also pay your bill online at: https://www.patientnotebook.com/AdultandPediatricUro/payment. You will also be enrolled to receive electronic statements if you provide our office with an email. If you do not wish to receive electronic statements, please contact our billing department.**

6. A **$40.00 service charge** will be assessed for returned checks.

7. **Pathology services** – if you have a biopsy taken, you may be billed separately for processing the slide and/or interpreting the slide. In some cases, a second opinion may be required to make a final diagnosis. Your insurance company may assess an additional co-payment for any lab or pathology services.

8. **Laboratory Services** – if you have blood drawn or urine cytology services, you may be billed separately by the laboratory that conducts the test(s). If your insurance company requires a specific laboratory for the processing of your blood work, it is your responsibility to notify the clinical staff at the time of the blood draw.

9. **If you cannot pay in full at time of service, please call** the business office at **(402) 399-7888** to make other arrangements. **Payments plans** are determined by the amount of the owed balance. The following guidelines will be followed:

* Balances up to $300 are to be paid in 3 monthly installments.
* Balances up to $600 are to be paid in 4 monthly installments
* Balances greater than $600 are to be paid in 6 monthly installments.

10. **Call to correct any billing errors promptly**. If you ignore our billing statements or telephone calls, we can only assume that you do not intend to pay for the medical services that were provided in good faith and your account will be forwarded to an outside collection agency.

11. **Referrals** – some insurance plans require that a referral from the primary care physician be obtained prior to be seen. It is the responsibility of the patient to obtain this referral. If a referral has not been obtained you may be responsible for a larger portion of your bill.

12. **Personal Injury** – we will not be a party to any litigation suits filed for personal injuries. We require payment in full and any payment from litigation is to be sought by you for reimbursement.

13. **Work Related Injuries** – pre-authorizations for care is the responsibility of the patient. If the prior authorization is not obtained, you are responsible for full payment at the time of service. If your workers compensation carrier has not paid your account within 45 days of the date of service, the owed balanced will become the responsibility of the patient.

I have read this policy and accept the terms as outlined above.

Signature: _____ Printed Name: _____ Date: _____