ADVANCED PELVIC SURGERY L.L.C.
Dr. R. Gregory Owens
7162 Liberty Centre Drive Suite B
West Chester, Ohio 45069

WHAT TO EXPECT ON YOUR FIRST PHYSICAL THERAPY VISIT

Your physician has recommended physical therapy with Kathleen Novicki, P.T. Kathleen sees patients on Monday and Wednesdays in West Chester, Ohio at Advanced Pelvic Surgery. She will be your physical therapist, but you will be billed through Advanced Pelvic Surgery. Dr. Robert Gregory Owens is the supervising physician at this office.

On your first visit, Kathleen will assess the strength, coordination, and flexibility of your pelvic floor muscles. Biofeedback may be used in your assessment. Biofeedback painlessly "reads" the pelvic floor muscles allowing you and your therapist to define your individual needs and rehabilitation program.

Kathleen will discuss with you the results of your evaluation, answer any questions or concerns, discuss realistic goals, explain the type of physical therapy needed, and discuss the expected frequency and duration of treatment.

You do not need to wear any special clothing to your first visit. Take all medications as normally scheduled. If you are menstruating at the time of your appointment, please do not cancel. Much, if not all, can be accomplished despite menses.

Please do not hesitate to call the office at 513-942-7640 with any questions.

Rev. 5-22-18

PATIENT REGISTRATION

PATIENT INFORMATION:

NAME:_____

SS#:_____ BIRTHDATE:_____

SEX: M F MARTIAL STATUS:_____ DRIVERS LICENSE#_____

ADDRESS:_____

CITY, STATE, & ZIP;_____

HOME PHONE: _____CELL PHONE:_____

EMPLOYER:_____

EMERGENCY CONTACT PERSON:_____

RELATIONSHIP:_____PHONE:_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME:_____

SS#:_____BIRTHDATE:_____

SEX: M F MARTIAL STATUS: _____DRIVERS LICENSE#: _____

ADDRESS: _____

CITY, STATE, & ZIP:_____

HOME PHONE:_____CELL:_____

EMPLOYER:_____

INSURANCE COVERAGE:

PRIMARY CARRIER:_____

SUBSCRIBER NAME:_____EFT DATE:_____

ID#_____GROUP#_____CO PAY:_____

CLAIMS ADDRESS:_____

I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the other party who accepts assignment. I authorize payment of medical benefits to the physician for all services rendered. I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for services rendered.

Signature:_____ Date:_____

ADVANCED PELVIC SURGERY, LLC 7162 Liberty Centre Dr., Ste. B, West Chester, OH 45069 (513) 942-7640

New Patient Consult HPI (PLEASE PRINT) **Date of visit**_____

Name_____ DOB _____ Age _____

Referring Doctor _____ Primary Doctor _____

What is the main reason for your visit? _____
How long have you had the problem? _____

What makes it better or worse? _____

Please list all your bladder, bowel or GYN surgeries_____

_____

Do you have urine loss with coughing or activity? [Yes] [No] With the urge to void? [Yes] [No] Do you have urinary urgency without leaking? [Yes] [No]

How many times a day? _____ Do you need pads? [Yes] [No] How many a day? _____

Do you have problems starting your urine stream? [Yes] [No] Slow stream? [Yes] [No] Emptying your bladder [Yes] [No] Dribbling? [Yes] [No]

How long can you go between urinations during the day? _____How many times do you void at night? _____
Do you wet the bed? [Yes] [No]

When was your last urinary tract infection? _____ Have you ever had kidney stones or blood in your urine? [Yes] [No] If so, what was done to treat it? _____

How often do you move your bowels? _____Do you have trouble moving your bowels? [Yes] [No]
If so what is the trouble? _____

Do you have problems controlling gas? [Yes] [No] Liquid Stool? [Yes] [No} Solid stool? [Yes] [No] If so, how often do you have accidents? _____ Do you need pads for stool incontinence? [Yes] [No]

Do you feel like your bladder, uterus or rectum has fallen? [Yes] [No] Does this affect intercourse? [Yes] [No] Is there tissue at or outside the vaginal opening? [Yes] [No]

How many Pregnancies? _____ How many children? _____ How many vaginal deliveries? _____
How many C-Sections? _____What difficulties did you have with labor and delivery? _____

When was you last period? _____What birth control do you use? _____

PREVENTIVE HEALTH MAINTENANCE:

When was your last? PAP/Annual _____ Normal/Abnormal Dexa Scan _____ Normal/Abnormal

Mammogram _____ Normal/Abnormal Colonoscopy _____Normal/Abnormal

Any Abnormal results/ Treatment Plans? _____

_____

_____

New Patient Consult **Date of visit**_____

DRUG ALLERGY	REACTION

Medical Problems_____

_____

_____

_____

Surgeries/Year Performed _____

_____

_____

Serious medical problems in your family_____

_____

Social History

Have you ever smoked? _____ How long? _____ Do you smoke currently_____ Packs/day _____

How often and how much do you drink? _____

Marital status? _____

Are you sexually active? _____ Any problems? _____

What is your occupation? _____

Are you depressed or do you have a history of depression? _____

Pharmacy:

NAME _____**STREET/CITY/CTATE/ZIP CODE** _____

PHARMACY PHONE NUMBER _____

Name _____ Date _____

MEDICATIONS/SUPPLEMENTS LIST

NAME	MG, IU, ETC.	TIMES/DAY

REVIEW OF SYSTEMS

Have you had any problems related to the following in the past **6 months**?

Circle **Yes** or **No:**

General:

Fever	Y	N
Weight change	Y	N
Tire Easily	Y	N

Eyes:

Change in vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N

Ears, Nose, Throat:

Sores	Y	N
Discharge	Y	N
Pain	Y	N

Respiratory:

Chronic Cough	Y	N
Asthma	Y	N
COPD	Y	N

Cardiovascular:

Shortness of breath	Y	N
Chest Pain	Y	N

Gastrointestinal:

Nausea/vomiting	Y	N
Reflux	Y	N
Diarrhea	Y	N
Bloody Stool	Y	N

Skin/Breast:

Breast Lumps	Y	N
Skin Rash	Y	N

Musculoskeletal:

Weakness	Y	N
Limited range of motion	Y	N
Joint Pain	Y	N

Neurological:

Seizures	Y	N
Burning or shooting pain	Y	N
Numbness	Y	N

Hematological:

Easy bruising	Y	N
Bleeding	Y	N
Swollen Glands	Y	N

Endocrine:

Thyroid problems	Y	N
Diabetes	Y	N

Psychiatric:

Depression	Y	N
Anxiety	Y	N

Please list details associated with any of the above _____

_____

Name:_____Date:_____

Quality of Life **Date of visit**_____

Has urine leakage and or prolapse affected your:	None	Slightly	Moderately	Greatly
Ability to do household chores?	0	1	2	3
Physical recreation such as walking?	0	1	2	3
Swimming or exercise?	0	1	2	3
Entertainment activities (movies, concerts, etc.)?	0	1	2	3
Ability to travel by car or bus more than 30 minutes?	0	1	2	3
Participation in social activities outside the home?	0	1	2	3
Emotional health (nervousness, depression, etc)?	0	1	2	3
Feeling frustrated?	0	1	2	3

Do you experience, and, if so, how much are you bothered by:				
Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency?	0	1	2	3
Urine leakage related to physical activity, coughing, or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdomen or genital area?	0	1	2	3

Name _____ Date _____

Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble.
The "sample" line shows you how to use the diary.

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	How much? oz, mL, cups	How many times?	How much urine?	How much urine?		Sneezing, lifting, arriving home, sleeping, etc.
Sample	Juice	8 ounces	✓✓	sm med lg	sm med lg	Yes No	Running
6–7 a.m.				sm med lg	sm med lg	Yes No	
7–8 a.m.				sm med lg	sm med lg	Yes No	
8–9 a.m.				sm med lg	sm med lg	Yes No	
9–10 a.m.				sm med lg	sm med lg	Yes No	
10–11 a.m.				sm med lg	sm med lg	Yes No	
11–12 noon				sm med lg	sm med lg	Yes No	
12–1 p.m.				sm med lg	sm med lg	Yes No	
1–2 p.m.				sm med lg	sm med lg	Yes No	
2–3 p.m.				sm med lg	sm med lg	Yes No	
3–4 p.m.				sm med lg	sm med lg	Yes No	
4–5 p.m.				sm med lg	sm med lg	Yes No	
5–6 p.m.				sm med lg	sm med lg	Yes No	
6–7 p.m.				sm med lg	sm med lg	Yes No	
7–8 p.m.				sm med lg	sm med lg	Yes No	
8–9 p.m.				sm med lg	sm med lg	Yes No	
9–10 p.m.				sm med lg	sm med lg	Yes No	
10–11 p.m.				sm med lg	sm med lg	Yes No	
11–12 mid.				sm med lg	sm med lg	Yes No	
12–1 a.m.				sm med lg	sm med lg	Yes No	
1–2 a.m.				sm med lg	sm med lg	Yes No	
2–3 a.m.				sm med lg	sm med lg	Yes No	
3–4 a.m.				sm med lg	sm med lg	Yes No	
4–5 a.m.				sm med lg	sm med lg	Yes No	
5–6 a.m.				sm med lg	sm med lg	Yes No	

Use this sheet as a master for making copies that you can use as a bladder diary for as many days as you need.

I used _____ pads today. I used _____ diapers today (write number).

Questions to ask my health care team: _____

ADVANCED PELVIC SURGERY, LLC
R. Gregory Owens, M.D.

7162 Liberty Centre Dr.
West Chester, OH 45069
Phone: 513/942-7640
FAX: 513/755-4736

❖ **CONSENT TO TREATMENT/TESTING**: I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.

❖ **RELEASE OF RECORDS**: I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or to their representatives, review organizations, or surveyors for accreditation, regulatory and/or licensing purposes, as necessary to determine benefits entitlement and to process payment claims for healthcare services provided. This authorization shall be valid only for the period of time necessary to process payment claims.

In consideration of admission and all facility services, the undersigned agrees to the following:

❖ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Advanced Pelvic Surgery, LLC of all insurance benefits, otherwise payable to me.

❖ **GUARANTEE OF ACCOUNT**: I unconditionally guarantee the payment in full to the facility of the total amount due them for said admission and/or facility services. I understand that I am financially responsible to the facility and/or physician for the charges not covered by the above assignment. I am also responsible for charges even if determined by my employer or insurance company to be unnecessary in their judgement.

❖ **I have read and do understand this form.**

_____ _____

Signature of Responsible Party Date

_____ _____

Relationship to Patient Witness

WAIVER OF FINANCIAL RESPONSIBILITY

ADVANCED PELVIC SURGERY, LLC
R. GREGORY OWENS, M.D. F.A.C.O.G.

PATIENT NAME: _____

PHYSICIAN NAME: R. Gregory Owens, M.D.

DATE OF SERVICE: _____

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES IN THE EVENT THAT MY INSURER DOES NOT COVER EXPENSES. IF YOU HAVE A DEDUCTIBLE AND IT HAS NOT BEEN MET, PAYMENT FOR SURGERY OR PROCEDURES IN THE OFFICE WILL HAVE TO BE PAID BEFORE SERVICES ARE RENDERED. AN INTEREST CHARGE OF 1 ½ % PER MONTH WILL BE ASSESSED FOR ANY OUTSTANDING PATIENT BALANCE AFTER THE FIRST STATEMENT IS SENT.

TO ASSIST YOU WITH YOUR MEDICAL CARE, WE PROVIDE THE FOLLOWING PAYMENT OPTIONS:

1. **CASH – INCLUDES PERSONAL CHECKS**
2. **VISA, MASTERCARD, DISCOVER, DINERS CLUB, JBC, AMEX**
3. **CareCredit – Patient payment plans that allow you to pay over time with convenient low minimum payments. With CareCredit, you enjoy these benefits:**
   - **Flexible Financing options**
   - **No annual fees or prepayment penalties**
   - **Quick and easy application**
   - **Receive a credit decision almost immediately**
   - **Start your recommended treatment immediately**

SIGNATURE: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____

DATE: _____

CONSENT TO DISCUSS

I, _____ give my consent to Advanced Pelvic Surgery

to discuss my medical condition with _____
Family Member or Friend

_____ _____
Patient Signature Date