ADVANCED UROGYNECOLOGY
Female Incontinence • Gynecology • Wellness
T: **407.898.9804** F: 407.898.9805

PATIENT INFORMATION

(Please Print)

Last Name _____ First Name _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____
Email Address _____ Best way to contact ☐ Home Phone ☐ Work Phone ☐ Cell
Social Security Number _____ Date of Birth _____
Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other
Preferred Language _____ Marital Status _____
Primary Care Physician _____
Who Referred You to Us? / How Did You Hear of Us?
_____
Occupation _____ Employer _____

Who is Financially Responsible for the Patient (Guarantor)?
☐ Self ☐ Spouse ☐ Parent ☐ Other
Last Name _____ First Name _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____
Social Security Number _____ Date of Birth _____

Primary Insurance
Name of Insurance _____ Phone _____
Mailing Address _____
Insured's ID/Policy # _____ Group # _____
Policy Holder's Name (if different than patient) _____ DOB _____
Relationship to Patient _____ SSN _____

Secondary Insurance - Please provide insurance card.
Name of Insurance _____ Phone _____
Mailing Address _____ City _____ St _____ Zip _____
Insured's ID/Policy# _____ Group # _____
Policy Holder's Name _____ DOB _____
Relationship to Patient _____ SSN _____

Emergency Contact (Parent/Guardian if patient is a minor)
Name _____ Relationship _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

How did you hear about us? (please check all that apply)
☐ Self ☐ Friend ☐ Advertisement (Lifestyles Magazine, Southwest Bulletin, AU Facebook, AU Website, Google, Other)
☐ Other: _____ ☐ Doctor/Health Care Provider

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to any evaluation or treatment that the assigned healthcare provider may deem necessary.

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Advanced Urogynecology. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____
Signature (patient, parent/legal guardian) Date

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Print Patient Name:_____ Date:_____

I hereby authorize the release or use of my / or the patient's individually identifiable health information ("protected health information") and medical record information by Advanced Urogynecology (the "Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your / the patient's care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your protected health information to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request, in writing, that we further restrict how your / the patient's protected health information is released or used to carry out our treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction(s); However, if we do agree, in writing, to your / the patient's requested restriction(s), such restrictions are then binding on the Practice.

I have been provided the opportunity to review the Practice's Notice of Privacy Practices in the waiting room and I understand I may receive a copy if I request it.

Signature of Patient (or Authorized Representative): _____

I acknowledge and agree that the Practice may disclose my / the patient's protected health information and medical record information to the following individuals: **(please initial line and write in name of individual)**

_____Spouse _____ _____ Parent _____

_____ Child _____ _____ Legal Guardian _____

_____ Other _____ _____ Power of Attorney _____

I agree that the Practice may also disclose the following types of information contained in my / the patient's medical record. **(please initial below):**

	Substance Abuse Information		HIV / AIDS Information
	Sexually Transmitted Disease Information		Mental Health Information
	Pregnancy Information if patient is under 18 years old.		

I agree and consent to the Practice releasing information to me in the following alternative **manners (please initial the appropriate spaces below):**

_____Via regular mail _____Via telephone _____Via email

_____Via home answering machine _____Via work voice mail

_____Via fax to my designated fax number which is: _____

The Practice may refuse to treat you if you / the patient's (or an authorized representative), do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date:_____ Time:_____AM / PM

_____ _____

Signature of Patient (or Authorized Representative) Please Print Name

FOR OFFICE USE ONLY:

Acknowledgement NOT obtained because:
- ☐ Patient or legal guardian declined to accept Notice of Patient Privacy Practices
- ☐ Patient received Notice of Patient Privacy Practices but declined to sign Acknowledgement
- ☐ Other _____

OFFICE POLICIES

Payment for co-payments, deductibles and coinsurance are expected at the time services are rendered. Any necessary financial arrangements are to be made prior to treatment. We bill only insurance we are contracted with and the patient is expected to know what coverage they have. I understand and agree to comply with Advanced Urogynecolgy's financial policy.

If your insurance requires a referral or authorization, you must have it prior to the time of service. Your appointment will be rescheduled if authorization is not obtained.

During the course of your treatment, separate charges for laboratory, hospital, or anesthesia services may occur. Our office is not responsible for billing these services. You may receive separate bills from these facilities. If you have questions regarding their charges, please contact these facilities directly.

Please do not call the office for prescription refills; instead have your pharmacy fax a refill request to our office and allow 3 days for processing.

Signature (patient, parent/legal guardian) Date

NO SHOW / CANCELLATION POLICY

Effective 8/13/2013

Our office reserves the right to charge the following fees to reschedule your appointment or surgical procedure.

Appointment Type	Amount	Notice Needed
Office visit, Follow up, Annual Visit	$ 25.00	2 business days
In Office Procedures	$100.00	3 business days
Surgery	$250.00	7 business days

This charge is not covered by insurance and therefore will be the responsibility of the patient/parent.

Patient Name Signature of patient/parent/guardian

Date