Valley Urogynecology Associates, Ltd.

Paul W. Marshburn, MD, FACOG
Felipe L.G. Videla, MD, FACOG
Shazia A. Malik, MD, FACOG
Daniel E. Stone, MD, FACOG

Board Certified in Female Pelvic Medicine and Reconstructive Surgery
1616 East Maryland Avenue
Phoenix, Arizona 85016-1302

Phone: (602) 788-1521
Fax: (602) 688-5420
www.valleyurogyn.com

Appointment Instructions

Patient: _____

Dear Ms./Mrs.:_____

You have been scheduled for an appointment on _____ , _____,20 _____ at ____:_____to see Dr. _____.

Enclosed are your pre-registration forms. Please complete these forms and return them to the office by mail or bring them in with you at your initial visit. Please bring all documentation **pertaining** to your visit (i.e., labs, ultrasound, x-ray's, etc.). This will make your registration quicker upon your arrival.

We ask that our patients arrive 15 to 30 minutes early for pre-registration and insurance verification.

Thank you for choosing our practice to take care of your needs.

Sincerely,

Anna Downer
Practice Manager

Valley Urogynecology Associates, Ltd.

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Personal Information:

Account #:_____
Name:_____
Date of Birth_____
Social Security#:_____
Marital Status:☐Single☐Married☐Divorced☐Widowed
Language Preference:_____
Ethnicity:_____

Provider and Pharmacy Information:

OK to Request Medication History:☐Yes☐No
Pharmacy:_____
Pharmacy Phone #:_____
Primary Care Provider:_____
Phone#:_____
Referring Provider: _____
Phone#:_____

Contact Information:

Home Address:_____
City:_____State:_____Zip:_____

Home Phone:_____
Cell Phone:_____
Work Phone:_____
OK to leave message:☐Yes☐No
Email Address:_____
OK to Email:☐Yes☐No

Occupation:_____
Employer:_____
Employer Address:_____
City:_____State:_____Zip:_____

Emergency Contact Name:_____
Relation:_____
Phone #:_____

Insurance Information:

Primary Insurance:_____
Policy Holder:_____
ID#:_____ Group:_____
Address:_____
Phone #:_____
Secondary Insurance:_____
Policy Holder:_____
ID#:_____ Group:_____
Address:_____
Phone #:_____
Responsible Party (Insurance Policy Holder)
Name:_____
Relation:_____
Employer: _____
Date of Birth:_____
Social Security #:_____
Phone #:_____
Address:_____
City:_____State:_____Zip:_____

PLEASE READ AND INITIAL THE BELOW STATEMENT

___If I have no medical coverage, I am aware that payment is due at the time of service for services rendered.

___I am aware that I am to pay my COPAY, COINSURANCE and DEDUCTIBLE at the time of service. If not paid at the time of service, I am aware that I will be **billed a $5.00 billing fee.**

___I hereby authorize to release any MEDICAL information which might be needed in connection with payment for medical serviced rendered. I request that all amounts payable under my medical insurance policies be made directly to the provider rendering services to me. When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any service deemed non-covered by my insurance company.

___I am aware that if I fail to pay my account and if it is deemed necessary to turn any past due balance over to collections, I have been informed that there will be an additional charge of **up to 10%** accessed in addition to my account balance.

___I am aware that I will give the office NOTICE **at least 24 to 48 hours in advance** for any cancellation and if I choose not to show for my appointment, I will be charged up to **$100.00** for a no show.

By signing below, I acknowledge that I have read and understand the above statements.

_____ _____

Signature Date

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REQUIRED ITEMS FOR YOUR INITIAL VISIT WITH VALLEY UROGYNECOLOGY ASSOCIATES, LTD. PHYSICIANS

- Current driver's license (Must be presented at every visit).
- Current medical insurance card(s) (Must be presented at every visit).
- A copy of your insurance referral (if you are required to have one by your insurance carrier). If unsure please contact your insurance company prior to your visit to confirm provider participation as well as approved procedures. If you do not have your referral or it has not been received by our office you may be asked to reschedule or choose to pay for the visit. Payment for you visit is ultimately your responsibility. Our office will make every effort to help you in this matter.
- List of all medication that you are taking including quality and dosage.
- Any blood test results (6 months or sooner).
- Any CT scans, ultrasound, or radiology reports within the last 6 months.
- Your primary physician's reports stating why you were referred.
- Any other type of information that would assist the physician with your initial appointment.
- According to our office policy if you have been scheduled for an appointment and you do not keep that appointment, you will be charged a missed appointment fee up to $100. You must call to cancel or reschedule at least 24 hours prior to that appointed time to avoid the fee.
- ALL COPAY, COINSURANCE AND DEDUCTIBLE ARE DUE AT THE TIME OF SERVICE, WE ACCEPT ALL MAJOR DEBIT/CREDIT CARDS, CASH OR CHECKS WITH VERIFICATION OF FUNDS.

Note: Please bring all items requested and payments with you the day of your appointment, or have them sent to our office prior to your visit.

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PATIENT RIGHTS AND RESPONSIBILITIES

We consider you a partner in your medical care. When you are well-informed, participate in treatment decisions, and communicate openly with health professionals, you help make your care as effective as possible. We encourage and respect the personal preferences and values of each individual. Patients have certain rights and responsibilities which should be given consideration during each episode of care. They are as follows:

1. In recognition of your human dignity, you have the right to, considerate and quality care that reflects your personal values and beliefs and is consistent with sound nursing and medical practices. You are responsible for being considerate of the needs of other patients and staff.
2. You have the right to expect your caregiver to make a reasonable response to your request for services. You have the responsibility to keep appointments or make appropriate notifications when this is not possible.
3. You have the right to every consideration concerning the privacy and confidentiality of your medical care and medical records. You have the responsibility to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, sensitivities or allergies to drugs and agents, and other matters relating to your health when asked by either the staff or physicians.
4. You have the right to expect reasonable continuity of care and assistance in locating alternatives when medically indicated.
5. You have the responsibility to report unexpected changes in your condition to the responsible practitioner as soon as possible. We cannot be held accountable for problems we are unaware exist.
6. You have the right to be informed of your condition and our explanation of your treatment program and to ask for clarification of the course of treatment if it is not understood. You are responsible to actively participate in the decisions regarding your treatment and cooperate in the agreed plan.
7. You have the right to be informed of alternative treatments and to choose among alternatives. You have the right to accept or refuse treatment to the extent permitted by law and to be informed of the medical consequences of your actions. You are responsible for your actions if you do not follow your caregiver's recommendations.
8. You have the right to examine and receive an explanation of charges related to your care and be provided with information available regarding payment methods. You have the responsibility to provide information necessary for claim processing and to assure that the financial obligations of your health care are fulfilled as promptly as possible. You have the responsibility of making sure payment is surrendered at time of service.
9. You have the right to be informed about the patient rights and responsibilities and the procedure for review and resolution of your complaints and concerns. You are responsible for adhering to the patient responsibilities as outlined.

The physicians, the medical staff, and the employees wish to treat our patients with fairness and concern, recognizing their needs and wishes, and satisfying them to the fullest extent possible.

Please sign and return with your documentation a copy will be given to you at check in.

Sincerely,

Management

_____ _____
PATIENT DATE

_____ _____
WITNESS DATE

Valley Urogynecology Associates, Ltd.

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Medical History - Initial Visit

Name: _____Date of Birth:_____Age: ____Date:_____

Referring Provider: _____ Primary Care Physician:_____

Reason for visit: _____

_____

Gynecologic History

Pregnancies (#) _____

Vaginal deliveries (#) _____

Largest (Birthweight) _____

Forceps/Vacuum _____

Episiotomy/Tear Yes/No _____

Cesarean deliveries (#) _____

Other _____

Last Pap Smear (year) _____ Normal/Abnormal

Last Mammogram: _____ Normal/Abnormal

Last Menstrual Period _____ Regular/Irregular

Painful Periods? Yes/No/NA

Future childbearing? Yes/No/Unsure

Menopause? Yes/No/Perimenopausal

Prior Hysterectomy? Yes/No/Unsure

If yes: Abdominal/Vaginal/Laparoscopic/Unsure

Cervix removed? Yes/No/Unsure

Ovaries taken? No/One/Both/Unsure

Prior Bladder suspension? Yes/No/Unsure

If yes: Type: (if known) _____

Cystocele repair? Yes/No Mesh? Yes/No

Rectocele Repair? Yes/No Mesh? Yes/No

Do you have? (answer all and circle answer)

Leakage of urine with activity Yes/No

Leakage of urine with urgency Yes/No

Leakage of urine with sex Yes/No/na

Difficulty emptying your bladder Yes/No

Dribbling after urinating Yes/No

Urinary frequency without leakage Yes/No

Burning or pain with urination Yes/No

Frequent or recent bladder infection(s) Yes/No

Blood in urine Yes/No

How often do you wake up to urinate? (#) _____

Constipation/straining Yes/No

Leakage of stool/soiling Yes/No

Pain with sex/intercourse Yes/No/na

Pelvic pressure or vaginal bulging Yes/No

Abnormal vaginal bleeding/discharge Yes/No

Past Surgical History

List all Operations. Check here if none _____

Year Type

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List All Medications. Check here if none _____

Medication Dose

_____

_____

_____

_____

_____

_____

_____

_____

_____

List All Allergies/Sensitivities. Check here if none___

Medication Reaction

_____

_____

_____

_____

_____

Reviewed by:_____Date:_____

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Name: _____ Date:_____

Past Medical History
Check if you have or **ever** had any of the following.
Check here if none___
Cardiovascular
Blood clots in legs or lungs _____
High Blood Pressure _____
Anemia _____
Angina/Chest Pain _____
Bleeding problems _____
Blood transfusions _____
Other: _____
Pulmonary
Asthma _____
COPD/Emphysema _____
Chronic Cough _____
Difficulty Breathing _____
Tuberculosis/Valley Fever _____
Other: _____
Gastrointestinal
Ulcers _____
Hiatal Hernia/Acid reflux _____
Hepatitis _____
Type: A/B/C/chronic/unsure
Irritable Bowel Syndrome _____
Inflammatory Bowel Disease _____
Type: Crohn's, Ulcerative, unsure
Diverticulosis/Diverticulitis _____
Rectal Bleeding _____
Other: _____
Urinary
Kidney Stones _____
Kidney Infections _____
Bedwetting _____
Bladder Pain (interstitial cystitis) _____
Bladder tumors _____
Other: _____
Neurological
Migraine Headaches _____
Stroke/TIA _____
Seizures/Convulsions _____
Neuropathy _____
Nerve pain/sciatica _____
Other: _____
Endocrine
Thyroid problems High/Low _____
Diabetes _____
Menopausal symptoms _____
Osteopenia/Osteoporosis _____
Other: _____
Other Conditions
Cancer Yes/No Kind:_____
Anxiety _____
Depression _____
Arthritis _____
Skin Conditions _____
Back Pain _____
Other: _____
_____
_____
Social History
Marital Status ___S___M___D___W___Sep
Exercise Yes/No _____
Do you smoke? Yes/No/Quit
How Much? _____
How Long (years) _____
Do you drink alcohol? Yes/No Rare/Mod/Heavy
Do you drink caffeine? Yes/No Rare/Mod/Heavy
Drug use? Yes/No/Quit _____
Other: _____
Family History (list family member affected)
Hypertension _____ _____
Heart Disease _____ _____
Diabetes _____ _____
Stroke _____ _____
Breast Cancer _____ _____
Ovarian Cancer _____ _____
Colon Cancer _____ _____
Other: _____
_____
Review Of Systems:

Skin	Neg/_____	Const	Neg/_____
ENT	Neg/_____	GI	Neg/_____
Neuro	Neg/_____	Heme	Neg/_____
Pysch	Neg/_____	Muscle	Neg/_____
Resp	Neg/_____	GU	Neg/_____
Cardio	Neg/_____	Endo	Neg/_____

Reviewed by:_____Date:_____

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Quality of Life & Symptoms of Distress Inventory

Name:_____Date:_____

Please answer each question by checking the best response between 0 ("NOT AT ALL") and 3 ("GREATLY")

Incontinence Impact Questionnaire

Has urinary leakage and/or prolapse affected your:	**0=NOT AT ALL**	**1=SLIGHTLY**	**2=MODERATELY**	**3=GREATLY**	
Ability to do household chores (cooking, housecleaning, laundry)?					PA
Physical recreation such as walking, swimming, or other exercise?					PA
Entertainment activities (movies, concerts, etc.)?					T
Ability to travel by car or bus more than 30 minutes from home?					T
Participation in social activities outside your home?					SR
Emotional health (nervousness, depression, etc.)?					EH
Feeling frustrated?					EH

Urogenital Distress Inventory

Has urinary leakage and/or prolapse affected your:	**0=NOT AT ALL**	**1=SLIGHTLY**	**2=MODERATELY**	**3=GREATLY**	
Frequent Urination?					I
Urine leakage related to the feeling of urgency?					I
Urine leakage related to physical activity, coughing or sneezing?					S
Small amounts of urine leakage (drops)?					S
Difficulty emptying your bladder?					S
Pain or discomfort in the lower abdomen or genital area?					OD
A feeling of bulging or protrusion in the vaginal area?					OD
Bulging or protrusion you can see in the vaginal area?					OD

PA= Physical Activity
T= Travel
SR= Social/Relationships
EH= Emotional Health
OD= Obstructive/Discomfort Symptoms
I= Irritative symptom
S= Stress Symptoms

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UROLOG INSTRUCTIONS

This chart is a record of your fluid intake (drinking), urinary output, and leakage (incontinence) of urine. Please complete this according to the following instructions prior to your scheduled appointment. Choose at least 24-hour period to keep this record when you can conveniently measure every void. Start the urology with your first AM void as in the sample below:

Time	Amount Voided oz or cc	Intake Amount oz or cc and type	Activity Related to Symptoms	Leakage with Stress Code	Leakage with Urgency Code	Urgency Without Leakage Code
6:45 AM	500 cc		Awake			
7:30 AM		12 oz Coffee				
8:00 AM			Sneeze	2		
9:00 AM			Running Water		3	

1. Record time of all voids, leakage, and intake of liquids.
2. Measure all urinary output in cc's or oz's.
3. Measure all intake in cc's or oz's.
4. Describe the activity you were performing at the time of the leakage. If you were not doing anything record whether you were sitting, standing, or lying down.
5. Estimate the amount of leakage occurring with stress *(i.e.* cough, laugh, sneeze, lifting, exercise) according to the following scale:
   CODE:
   1 = damp, only a few drops
   2 = wet underwear or pad
   3 = soaked through clothing, or emptied bladder
6. Estimate the amount of leakage occurring with a strong urge to void (no stress) using the same scale above.
7. Note any significant urgency that occurred without leakage
8. After you have completed the 24-hour diary, make sure to bring it with you to your appointment.

1 cup = 8oz = 240cc
1 oz = 30cc

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Urolog

(Record all intake for at least a 24-48 hour period)

Time	Amount Voided oz or cc	Intake Amount oz or cc and type	Activity Related to Symptoms	Leakage with Stress Code	Leakage with Urgency Code	Urgency Without Leakage Code

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy to your health information. We are required by law to maintain the confidentiality of your health information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to disclose health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health or safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by laws appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by the law.
7. To correctional institutions or Jaw enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Worker' s Compensation or similar programs.

Notice of Privacy Practice for Protected Health Information

Paul W. Marshburn, M.D. Felipe L.G. Videla, M.D. Shazia A. Malik, M.D. Daniel E. Stone, M.D.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information al so includes payment, billing and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course or care. We may al so disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions and to family members who are helping with your care.

Payments: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plans.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders We may also contact you to provide information about treatment alterna11ves or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain Requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries or events.

Research: We may use of disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vita l statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits. eligibility for government programs and similar activities.

Judicial and administrative proceedings: We may disclose vita l statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Law enforcement Purposes: We may disclose information in response to an appropriate subpoena or court order.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat of your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces. we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Sign In Sheet: We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Website: If we maintain a website that provides information about our office, this notice will be on the website.

In any other situation. we will ask for your written authorization before using or disclosing any identifiable health information about you. If you chose to sign an authorization to disclose information, you can later evoke that authorization to stop any further uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health in formation. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect. or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information and to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Private Practice

We may change our policies at any time. Before we make a significant change in our policies. we will change our Notice and post the new Notice in the waiting room.

You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights. or if you disagree with a decision we make about your records, you may contact the person listed below. You may also send a written complaint to the U.S Department of Health and Human services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have question s, requests, or complaints, please contact:

Anna Downer
Privacy Officer
1616 E Maryland Ave
Phoenix, AZ 850 16-1302
(602) 788-1521

Effective Date: December 2, 2013

I _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Please provide us with a list of people whom we may discuss your health/account with; not to include physicians you see:

Signed: (Patient or legally authorized signature)

_____

Printed name if signed on behalf of the patient:

_____

Relationship to patient (parent , legal guardian, personal representative, etc.)

_____

Date: _____

If not signed, reason why acknowledgment was not obtained:

_____

_____

_____.

There will be a charge of 50-$ 100 if appointments are not canceled by patient or representative within 24 hours. Initial here please:

VALLEY UROGYNECOLOGY ASSOCIATES, LTD

This form serves as acknowledgement of Patient Financial Responsibility

A. Notifier:

B. Patient Name: **C. Account Number:**

Advance Beneficiary Notice of No coverage (ABN)

NOTE: If your Insurance Company doesn't pay for your visit below [D], due to pre-existing condition, your plan is out of network or is non-covered, you are responsible for the procedures listed below.

D. PROCEDURE/S CODES:	E. Reason Insurance Company may Not Pay:	F. Estimated Cost
New patient visit **CPT: 99201-99205, 99241-99245, 51701, 81000, 76705, 51798**	**Insurances will only pay for services that they feel are medically necessary, although your physician feels the procedure is necessary for his/her plan of care. If a particular service is not considered reasonable and necessary, services will be denied and become the responsibility of the patient.**	**$85.00-$275.00** **$85.00-$350.00** **$150.00** **$18.00** **$240.00** **$55.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the procedures listed **above in section [D]**. You may ask to Pay for the procedure now, but I also want My Insurance Company billed for an official decision on payment I understand that if my Insurance Company may not pay, and I am responsible for payment if they don't, but **I can appeal to My Insurance Company. I am further aware that this visit may be out of network you have obtained an out of network authorization for my procedure/s and I may receive a higher out of pocket expense then if provider was in network with my plan.** If My Insurance Company does pay, you will refund any payments I made to you, less co-pays or deductibles. **Initial here_____**

☐ **OPTION 2.** I want the procedure/s **above in section [D]**, but do not bill my Insurance Company. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my Insurance Company is not billed. Initial here_____**

H. Additional Information:

This notice gives our opinion, not an official Insurance decision. If you have other questions on this notice contact our billing department (602-788-1521) or your Insurance Carrier:

Signing below means that you have received and understand this notice. You will also receive a copy. **If you do not understand this notice please feel free to consult our billing department.**

I. Signature:	J. Date:

Valley Urogynecology Associates, Ltd.

Paul W. Marshburn, MD, FACOG
Felipe L.G. Videla, MD, FACOG
Shazia A. Malik, MD, FACOG
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Board Certified in Female Pelvic Medicine and Reconstructive Surgery
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This will authorize our office to release the following medical information to the doctor you have listed below. Per HIPAA regulations this office will only provide the medical records of our treatments. This document is only good for thirty days and you have the right to revoke at any time in writing.

Please allow 5 to 7 days for processing.

☐ History and physical
☐ Hospital summary
☐ Office summary
☐ Operative report
☐ Pathology and lab results
☐ Imaging results
☐Pap smear results
☐ Other _____

Physicians name or Hospital:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

Patient Name:_____ Date Of Birth:_____

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Date Processed:_____ by whom: _____

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RE:_____
(Name Records Held)

DOB:_____

Dear Doctor:

The above patient is now under care in this office. Please send a summary of the patient's past medical history for the period of _____.

Please include:

☐ History and physical
☐ Hospital summary
☐ Office summary
☐ Operative report
☐ Pathology and lab reports
☐ X-ray reports
☐ Pap smear reports
☐ Other _____

To Dr: _____ Date:_____

Phone: _____ Fax #:_____

This is to authorize you to give Dr._____ any information you have regarding my medical history, physical condition, and treatment you have given me.

Patient Signature: _____

Date: _____