7162 Liberty Centre Dr Suite B
West Chester Township, OH 45069

https://www.google.com/maps/place/7162+Liberty+Centre+Dr+Suite+B,+West+Chester+Township,+OH+45069/@39.372602,-84.3889807,17z/data=!3m1!4b1!4m5!3m1!1s0x0:0x0!8m2!3d39.372602!4d-84.3889807
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 INFORMATION:

NAME: ________________________________

FIRST  MIDDLE  LAST

SS#: __________________ BIRTHDATE: ________________________________

SEX: M  F  MARITAL STATUS: __________________ DRIVERS’ LICENSE #

ADDRESS: ________________________________

CITY, STATE & ZIP: ________________________________

HOME PHONE: ( ) __________________ WORK PHONE: ( ) __________________

EMPLOYER: ________________________________

EMERGENCY CONTACT PERSON: ________________________________

RELATIONSHIP: __________________ PHONE: ( ) __________________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT):

NAME: ________________________________

FIRST  MIDDLE  LAST

SS#: __________________ BIRTHDATE: ________________________________

SEX: M  F  MARITAL STATUS: __________________ DRIVERS’ LICENSE #

ADDRESS: ________________________________

CITY, STATE & ZIP: ________________________________

HOME PHONE: ( ) __________________ WORK PHONE: ( ) __________________

EMPLOYER: ________________________________

INSURANCE COVERAGE

PRIMARY CARRIER: ________________________________

SUBSCRIBER NAME: __________________ EFFECT DATE: __________________

ID#: __________________ GROUP #: __________________ COPAY AMT

CLAIMS ADDRESS: ________________________________

SECONDARY CARRIER: ________________________________

SUBSCRIBER NAME: __________________ EFFECT DATE: __________________

ID#: __________________ GROUP #: __________________ COPAY AMT

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 party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

RESPONSIBLE PARTY SIGNATURE ___________________________ DATE ____________
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 children do you have? ________ How many vaginal deliveries? ________ How many C-Sections? ________ What difficulties did you have with labor and delivery? ___________________________

When was your last period? ___________________________ What birth control do you use? ___________________________

When was your last PAP? ___________________________ Was it normal? [Yes] [No] What was done to treat the abnormality? ___________________________

When was your last mammogram? _________________ Was it normal?[Yes] [No] What was done to treat the abnormality? ___________________________
New Patient Consult

Date of visit

<table>
<thead>
<tr>
<th>DRUG ALLERGY</th>
<th>REACTION</th>
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</table>

Medical Problems

Surgeries/Year Performed

Serious medical problems in your family

Social History

How you ever smoked? 

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/STATE/ZIP CODE _____________________________

PHARMACY PHONE NUMBER _____________________________

Name _____________________________ Date _____________________
<table>
<thead>
<tr>
<th>NAME</th>
<th>MG, IU, ETC.</th>
<th>TIMES/DAY</th>
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# REVIEW OF SYSTEMS

Have you had any problems related to the following systems in the past 6 months? Circle Yes or No

**General:**
- Fever
  - Y
  - N
- Weight change
  - Y
  - N
- Tired Easily
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Skin/Breast:**
- Breast Lumps
  - Y
  - N
- Skin Rash
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Musculoskeletal:**
- Weakness
  - Y
  - N
- Limited Range of Motion
  - Y
  - N
- Joint Pain
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Eyes:**
- Change in Vision
  - Y
  - N
- Cataracts
  - Y
  - N
- Glaucoma
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Neurological:**
- Seizures
  - Y
  - N
- Burning or Shooting Pain
  - Y
  - N
- Numbness
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Respiratory:**
- Chronic Cough
  - Y
  - N
- Asthma
  - Y
  - N
- COPD
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Hematological:**
- Easy Bruising
  - Y
  - N
- Bleeding
  - Y
  - N
- Swollen Glands
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Cardiovascular:**
- Shortness of Breath
  - Y
  - N
- Chest Pain
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Endocrine:**
- Thyroid Problems
  - Y
  - N
- Diabetes
  - Y
  - N
- Other ____________________________
  - None of these above ___

**Gastrointestinal:**
- Nausea/Vomiting
  - Y
  - N
- Reflux
  - Y
  - N
- Diarrhea
  - Y
  - N
- Bloody Stool
  - Other ____________________________
  - None of these above ___

**Psychiatric:**
- Depression
  - Y
  - N
- Anxiety
  - Y
  - N
- Other ____________________________
  - None of these above ___

---

NAME ____________________________ DATE ____________________________
Quality of Life

<table>
<thead>
<tr>
<th>Has urine leakage and or prolapse affected your:</th>
<th>Date of visit__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to do household chores?</td>
<td>None</td>
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<tr>
<td>Physical recreation such as walking?</td>
<td>0</td>
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<tr>
<td>Swimming or exercise?</td>
<td>0</td>
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<tr>
<td>Entertainment activities (movies, concerts, etc.)?</td>
<td>0</td>
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<tr>
<td>Ability to travel by car or bus more than 30 minutes?</td>
<td>0</td>
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<tr>
<td>Participation in social activities outside the home?</td>
<td>0</td>
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<tr>
<td>Emotional health (nervousness, depression, etc)?</td>
<td>0</td>
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<tr>
<td>Feeling frustrated?</td>
<td>0</td>
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</tbody>
</table>

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 ____________________
<table>
<thead>
<tr>
<th>Time</th>
<th>Drinks</th>
<th>Urine</th>
<th>Accidental leaks</th>
<th>Did you feel a strong urge to go?</th>
<th>What were you doing at the time?</th>
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<td>2 cons</td>
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<tr>
<td>7-8 p.m.</td>
<td>Soda</td>
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<td>Yes</td>
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<td>8-9 p.m.</td>
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<td>No</td>
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<td>9-10 p.m.</td>
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<td>Yes</td>
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<td>10-11 p.m.</td>
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<td>Yes</td>
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<td>11-12 midnight</td>
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<td>Yes</td>
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<td>12-1 a.m.</td>
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<td>No</td>
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<td>1-2 a.m.</td>
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<td>Yes</td>
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<td>2-3 a.m.</td>
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<td>Yes</td>
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<td>3-4 a.m.</td>
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<td>Yes</td>
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<td>4-5 a.m</td>
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<td>Yes</td>
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<td>5-6 a.m</td>
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<td>Yes</td>
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</table>

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

Questions to ask my health care team:

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_Let's Talk About Bladder Control for Women_ is a public health awareness campaign conducted by the National Kidney and Urologic Diseases Information Clearinghouse (NKUDIC), an information dissemination service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health.
CONSENT TO DISCUSS

I, ____________________________, give my consent to Advanced Pelvic Surgery to discuss my medical condition with ____________________________.

                                             Family Member or Friend

________________________________________  __________________________
Patient Signature                           Date
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 ¹⁄₂ % 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: ________________________________