

# Google Maps 7162 Liberty Centre Dr Suite B



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

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

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## **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.

PATIENT REGISTRATION

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: \_\_\_\_\_ EFFT DATE: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ COPAY AMT \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_

SECONDARY CARRIER: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ EFFT 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 you 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 \_\_\_\_\_

**DRUG ALLERGY**

**REACTION**

DRUG ALLERGY	REACTION

**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/CTATE/ZIP CODE \_\_\_\_\_

PHARMACY PHONE NUMBER \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_



# 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
Tire Easily	Y	N
Other _____		
None of these above	___	

## Eyes:

Change in Vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N
Other _____		
None of these above	___	

## Ears, Nose, Throat:

Sores	Y	N
Discharge	Y	N
Pain	Y	N
Other _____		
None of these above	___	

## Respiratory:

Chronic Cough	Y	N
Asthma	Y	N
COPD	Y	N
Other _____		
None of these above	___	

## Cardiovascular:

Shortness of Breath	Y	N
Chest Pain	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	___	

## 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	___	

## Neurological:

Seizures	Y	N
Burning or Shooting Pain	Y	N
Numbness	Y	N
Other _____		
None of these above	___	

## Hematological:

Easy Bruising	Y	N
Bleeding	Y	N
Swollen Glands	Y	N
Other _____		
None of these above	___	

## Endocrine:

Thyroid Problems	Y	N
Diabetes	Y	N
Other _____		
None of these above	___	

## Psychiatric:

Depression	Y	N
Anxiety	Y	N
Other _____		
None of these above	___	

**Quality of Life**

Date of visit \_\_\_\_\_

<b>Has urine leakage and or prolapse affected your:</b>	<b>None</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Greatly</b>
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 \_\_\_\_\_






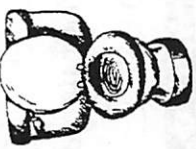



# Your Daily Bladder Diary

This diary will help you and your health care team. Bladder diaries help show the causes of bladder control trouble. The "sample" line (below) will show you how to use the diary.

Your name: \_\_\_\_\_  
Date: \_\_\_\_\_

ACCIDENTS											
Time	Drinks	Urine	Accidental leaks	Did you feel a strong urge to go?	What were you doing at the time?						
	What kind? How much?	How many times? How much? (circle one)	How much? (circle one)	Circle one	Sneezing, exercising, having sex, lifting, etc.						
Sample	Coffee 2 cups	✓  sm  med  lg	 sm  med  lg	Yes <input type="radio"/> No <input checked="" type="radio"/>	Running						
6-7 a.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
7-8 a.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
8-9 a.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
9-10 a.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
10-11 a.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
11-12 noon		  	  	Yes <input type="radio"/> No <input type="radio"/>							
12-1 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
1-2 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
2-3 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
3-4 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
4-5 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
5-6 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							
6-7 p.m.		  	  	Yes <input type="radio"/> No <input type="radio"/>							

# ACCIDENTS

 <b>Time</b> 	 <b>Drinks</b> <i>What kind? How much?</i>	 <b>Urine</b> <i>How many times? How much? (circle one)</i>	 <b>Accidental leaks</b> <i>(circle one)</i>	 <b>Did you feel a strong urge to go?</b> <i>Circle one</i>	 <b>What were you doing at the time?</b> <i>Sneezing, exercising, having sex, lifting, etc.</i>
Sample	Soda 2 cans	✓ <input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input checked="" type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input checked="" type="radio"/>	Laughing
7-8 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
8-9 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
9-10 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
10-11 p.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
11-12 midnight		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
12-1 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
1-2 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
2-3 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
3-4 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
4-5 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	
5-6 a.m.		<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	<input type="radio"/> sm <input type="radio"/> med <input type="radio"/> lg	Yes <input type="radio"/> No <input type="radio"/>	

I used \_\_\_\_\_ pads. I used \_\_\_\_\_ diapers today (write number).

Questions to ask my health care team: \_\_\_\_\_

**CONSENT TO DISCUSS**

I, \_\_\_\_\_, give my consent to Advanced Pelvic  
Surgery to discuss my medical condition with \_\_\_\_\_.  
**Family Member or Friend**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**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**

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- ❖ **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: \_\_\_\_\_