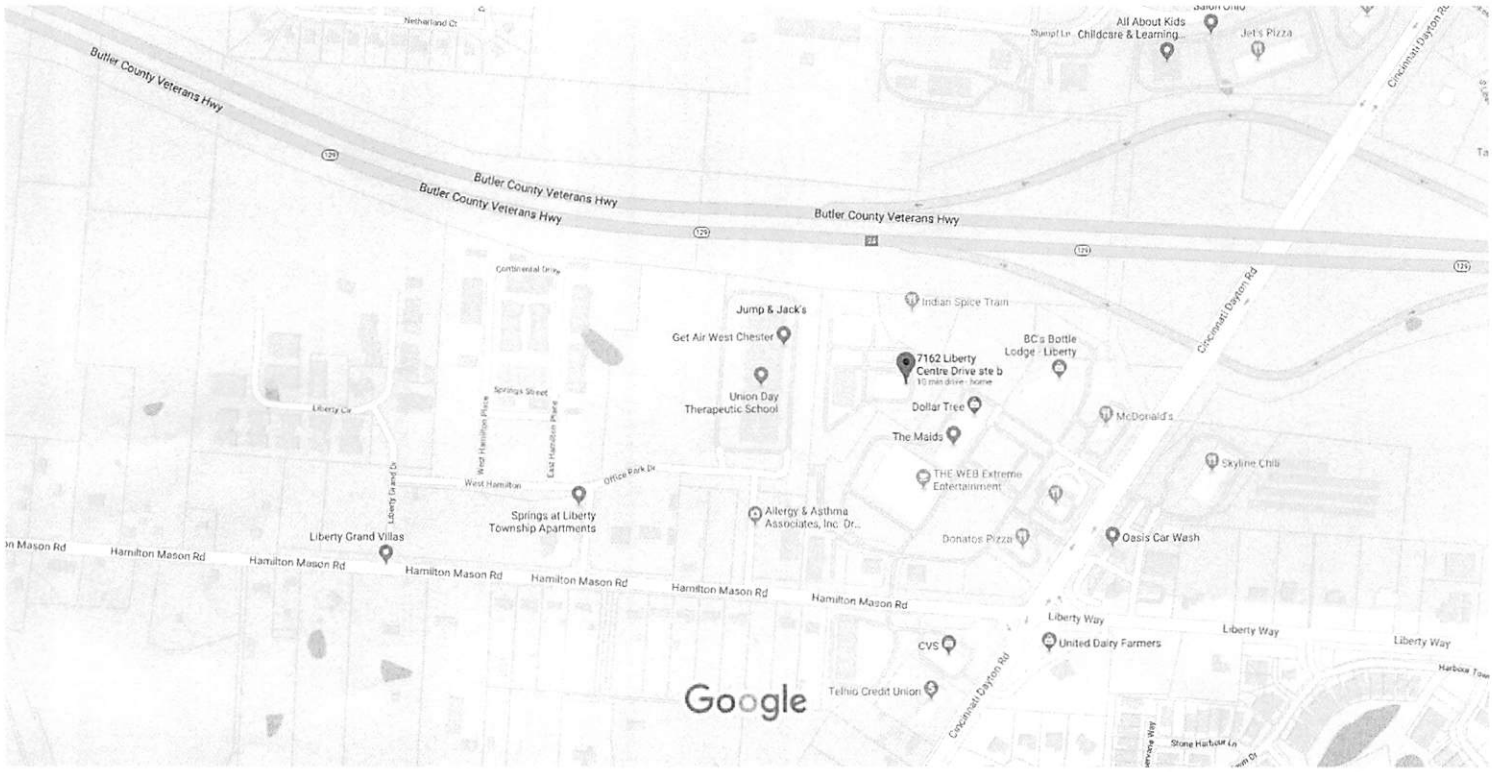
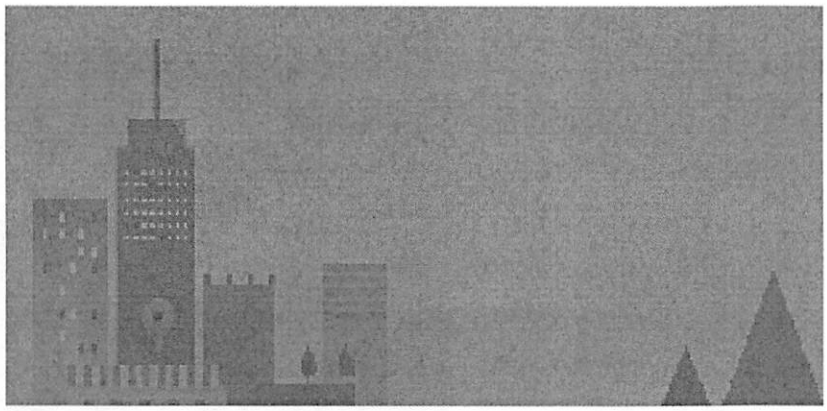
Google Maps 7162 Liberty Centre Dr ste b



Map data ©2018 Google 200 ft



7162 Liberty Centre Dr ste b

West Chester Township, OH 45069

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

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

New Patient GYN Consult HPI **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_____

_____

When was your last urinary tract infection? _____

How often do you move your bowels? _____

Do you have trouble moving your bowels? [Yes] [No] If so what is the trouble? _____

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

Contraception – Current Method _____

Menopause: ___ Hot Flashes ___Vaginal Dryness ___Night Sweats ___Memory/Concentration

Sexual Problems: ___Libido ___Orgasmic Dysfunction ___Painful Intercourse ___Vaginismus

When was you last period? _____

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 GYN Consult **Date of visit**_____

Medications

_____

_____

_____

_____

Drug Allergies _____

Medical
Problems_____

_____

_____

_____

Surgeries_____

_____

_____

Serious medical problems in your
family_____

_____

Social History

Have you ever been a smoker? _____ Sexual Problems:

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 _____ CITY/STATE/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 ___

NAME _____ 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

❖ 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 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 _____.

_____ _____

Patient Signature Date