

## Patient Demographic Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F \_\_\_ M \_\_\_ Email: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Family Doctor Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred:  TV  INS  YP  RADIO  FRIEND  INTERNET  OTHER \_\_\_\_\_

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### **(PLEASE FILL OUT INSURANCE SECTION COMPLETELY)**

Primary Ins: \_\_\_\_\_ Secondary Ins: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Grp# \_\_\_\_\_ ID#: \_\_\_\_\_ Grp# \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**NOTE: If your insurance requires a referral or authorization for office visits, it is your responsibility to obtain this prior to your visit.**

#### ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Understanding Women, Thomas Laser Center and Laser Surgery Center for all services rendered. I hereby authorize Understanding Women, Thomas Laser Center and/or Laser Surgery Center to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

## Financial Policy

Thank you for choosing our office. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our billing personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia and Lab fee.** We will submit for the Physician and Facility. If a procedure is generally deemed to be "cosmetic" or "non medically necessary", we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

### **IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.**

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, Discover or cash.

***All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.***

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a \$40 fee for the following: Electronic copy of medical records to a patient or insurance company.

There will be a \$50 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

**REFUNDS FOR AESTHETIC SERVICES:** All treatments (Single and/or packages) are Non-Refundable. Unused pre-paid treatments are not eligible for a refund but you may apply the credit toward future services or product.

**PRODUCTS PURCHASES:** Products are Non-Refundable or Exchangeable.

**It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.**

**I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient's request.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

Patient Communication Authorization

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

\_\_\_\_\_ Home phone number Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Mobile/Cell number Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Work phone number Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Call only this number. \_\_\_\_\_ Leave a message: \_\_ yes \_\_ no

\_\_\_\_\_ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

\_\_\_\_\_

\_\_\_\_\_ This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_



# PATIENT ASSESSMENT QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## Instructions

This questionnaire is to help assess your DAILY urinary habits and pelvic discomfort. **(This includes everyday not only pertaining during your menstrual cycle).**

For each question below, please circle the answer that best describes how you feel. Then, mark your score (0 to 4) for each Answer in the column on the right. When you are finished, add up the number in this column for your total score.

	0	1	2	3	4	START OF THERAPY MONTH 1 SCORE	MONTH 3 SCORE
<b>1</b> How many time do you go to the bathroom?	3-6	7-10	11-14	15-19	20+		
<b>2</b> How many time do you go to the bathroom at night?	0	1	2	3	4+		
<b>3</b> If you get up at night to go to the bathroom, does It bother you?	Never	Mildly	Moderate	Severe			
<b>4</b> Are you currently sexually active? <b>YES</b> ___ <b>NO</b> ___							
<b>5</b> If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
<b>6</b> If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
<b>7</b> Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)? <b>If you do not have pain, please skip question 8.</b>	Never	Occasionally	Usually	Always			
<b>8</b> a. If you have pain, is it usally....	No Pain	Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
<b>9</b> Do you have urgency after going to the bathroom? <b>If you do not have urgency, please skip final question.</b>	Never	Occasionally	Usually	Always			
<b>10</b> a. If you have urgency, is it usually....	No urgency	Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
<b>TOTAL SCORE</b>							

## GYN HISTORY

**Patient Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_ **Date:** \_\_\_\_\_

How many pregnancies: \_\_\_\_\_ Are you pregnant: Y / N Do you plan to become pregnant: Y / N Are you breastfeeding: Y / N

Date of last:

Menstrual period: _____	Pelvic U/S: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
Endometrial Biopsy: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal	Bone Density Scan: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
Pap Smear: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal	Colonoscopy: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
Abnormal pap: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal	Mammogram: _____ Result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
Treatment: <input type="checkbox"/> burning <input type="checkbox"/> freezing <input type="checkbox"/> laser	

Chief Complaint and Review of Systems

<input type="checkbox"/> Routine gynecological exam	<input type="checkbox"/> Painful periods	Other _____
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Pap only	_____
<input type="checkbox"/> Anemia	<input type="checkbox"/> PMS	_____
<input type="checkbox"/> Bladder control problems	<input type="checkbox"/> Prolapse	_____
<input type="checkbox"/> Breast mass/discharge	<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Heavy vaginal bleeding	<input type="checkbox"/> STD screening	
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Vaginal discharge	
<input type="checkbox"/> Menopausal symptoms		

Method of contraception:  Vasectomy  Tubal Pill/Patch  Injectable  IUD  Barrier  Essure

Sexual history:  Heterosexual  Homosexual  Bisexual

Received treatment in past for:  Gonorrhea  Chlamydia  Herpes  Syphilis  Genital Warts

Would you like testing for sexually transmitted diseases:  Yes  No

Are you done with childbearing:  Yes  No

Are/were your periods usually:  Regular (every 21-35days)  Irregular

Do you have more than one period in a month:  Yes  No

How long does your period last: \_\_\_\_\_ Do you have painful periods:  Yes  No

How long has the bleeding been a problem: \_\_\_\_\_

Do you use double protection:  Yes  No Do you change protection hourly or less:  Yes  No

Are you exceptionally tired or weak during your period:  Yes  No

Does your period impact on personal, social, or work activities:  Yes  No

Have you used any treatment or over the counter medications for you bleeding (hormones, birth control pills, iron, etc.):  Yes  No  
If yes, what treatment: \_\_\_\_\_

Do you have recent (past 12 months) onset bloating:  Yes  No

Do you have unexplained weight loss:  Yes  No

Do you feel full quickly (early satiety) when you haven't eaten much:  Yes  No

Do you have difficulty with bowel movements:  Yes  No

Do you feel a bulge from you vaginal area or feel like something is falling out:  Yes  No

Do you experience abdominal swelling, pressure or pain:  Yes  No

Do you have new onset lower back pain or leg pain that cannot be attributed to an injury:  Yes  No

Do you experience vaginal pain, pressure bleeding or spotting:  Yes  No

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