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 _____

(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_____

MEDICAL HISTORY

Patient Name: _____Marital Status:_____ Age_____D.O.B:_____

Reason for today's visit:_____

DrugAllergies:_____

Are you allergic to Latex: __ Yes __No Hepatitis: __Yes __No HIV: __Yes __No

Past Medical History	**Past Surgical History/Year**	**Family History**	Family Member (Immediate)	**Current Medication/Vitamins Name/Dosage**
__Hypertension	__Gallbladder _____	__Heart Disease	_____	__SEE LIST
__Diabetes	__Hemorrhoids _____	__Breast Cancer	_____	_____
__Long term steroid use	__Hysterectomy _____	__GYN Cancer	_____	_____
__ Seizures	__Heart Surgery _____	__Blood clots in	_____	_____
__Heart disease	__Pace maker _____	lungs or legs	_____	_____
__Stroke	__Defribulater _____	__ Colon/Bower Cancer	_____	_____
__Cancer	__Prostate _____	__ Stroke	_____	_____
__Cholesterol disorder	__Bowel Surgery _____	__ Prostate Cancer	_____	_____
__Thyroid disease	__Tubal ligation _____	__Other_____	_____	_____
__Kidney disorder	__Thyroid Surgery _____	_____		_____
__Bleeding disorder	__C-section _____	_____		_____
__Lupus/Autoimmune Dis	__Bariatric Surgery _____	_____		_____
__Gout	__Cosmetic(type)_____	_____		_____
__Other_____	__Other_____	_____		_____
_____				

Social History:

__Other_____ Tobacco use: __Everyday __Some days __Former__ Never

_____ _____

Patient Signature **Date**

OFFICE USE ONLY

HT:_____ WT:_____ HGB:_____

BP:_____ P:_____ PREG TEST:_____

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

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:_____
Endometrial Biopsy:_____Result: __normal__abnormal
Pap Smear:_____Result: __normal__abnormal
Abnormal pap:_____Result: __normal__abnormal
Treatment:__burning__freezing__laser

Pelvic U/S:_____Result: __normal__abnormal
Bone Density Scan:_____Result: __normal__abnormal
Colonoscopy:_____Result: __normal__abnormal
Mammogram:_____Result: __normal__abnormal

Chief Complaint and Review of Systems

_____Routine gynecological exam
_____Abdominal pain
_____Anemia
_____Bladder control problems
_____Breast mass/discharge
_____Heavy vaginal bleeding
_____Hemorrhoids
_____Menopausal symptoms
_____Painful periods
_____Pap only
_____PMS
_____Prolapse
_____Rectal bleeding
_____STD screening
_____Vaginal discharge
Other_____

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