FLORIDA BLADDER
INSTITUTE

Specialized Diagnostic, Treatment and Rehabilitative Care for Women with Incontinence, Pelvic & Bladder Disorders

Name: _____
First Last Maiden

Address: _____

Permanent Address (if different from above): _____

City, State, Zip: _____

Social Security Number: _____ Age: _____ Marital Status: S M W D SEP

Birth Date: _____ Religion: _____ Race: _____

Referred By: _____

Ethnicity: 1) Hispanic___ 2) Non-Hispanic___ 3) I prefer not to disclose___ Preferred Language: _____

Home #_____ Work # _____ Cell # _____

Consent to receive automated calls Y or N? Consent to receive text messages Y or N?

Email: _____
May we send you medical information via your e-mail Y or N?

Preferred Pharmacy: _____ Pharmacy Phone#: _____

Patient's Employer: _____

Spouse/Parent Name: _____ Spouse's DOB: _____

Spouse's Employer: _____

Work # _____ Cell # _____

Spouse's S.S. # _____ Person Responsible for Bill: _____

All payments are due at the time of service. Charges will be billed to your insurance carrier.

Forms of payment accepted: Cash, Check, Money Order, Visa, MasterCard, American Express, and Discover.

How do you intend to pay for today's visit? _____

Who may we contact in case of emergency? _____ Phone # _____

DO YOU HAVE HEALTH INSURANCE COVERAGE?

Insurance Company: _____ Medicare: _____ Medicaid: _____

Policy Holder: _____ Policy Holder's SS# _____ DOB: _____

Policy Holder's Employer: _____

Relationship to Patient: _____ Policy/ID # _____ Group/Account #_____

SECONDARY INSURANCE COVERAGE?

Insurance Company: _____ Policy Holder: _____

Policy/ID #_____ Group/Account # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Florida Bladder Institute to furnish information to all insurance carriers concerning my illness and treatments and hereby assign all payments for medical services rendered to myself or my dependents to Florida Bladder Institute. I understand that I am responsible for any amount not covered by my insurance. In the event that an outside collection agency is necessary to enforce payment of the account, I agree to pay for all collection fees deemed reasonable.

_____
Patient Signature Date

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PATIENT HEALTH HISTORY QUESTIONAIRE

NAME_____ DATE_____

PRIMARY CARE DOCTOR_____ REFERRED BY_____

PHARMACY USED/LOCATION_____

ALLERGIES _____**NONE**

MEDICATION OR SUBSTANCE	REACTION
1._____	
2._____	

MEDICATIONS _____**NONE**

MEDICATION	DOSAGE	FREQUENCY	REASON
1._____			
2._____			
3._____			
4._____			

	YES	NO	IF SO, HOW MUCH?
DO YOU SMOKE:	____	____	_____
HAVE YOU EVER SMOKED	____	____	_____
DO YOU CURRENTLY SEE A PAIN SPECIALIST	____	____	_____
ARE YOU CURRENTLY INVOLVED IN ANY MEDICALLY RELATED LAWSUITS	____	____	_____

GENERAL HEALTH SCREENINGS

DATE OF LAST PAP SMEAR _____

DATE OF LAST BONE DENSITY SCAN _____

DATE OF LAST COLONOSCOPY _____

DATE OF LAST MAMMOGRAM _____

NUMBER OF PREGNANCIES _____

LAST MENSTRUAL PERIOD _____

CURRENT CONTRACEPTION _____

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PASTGYNECOLOGICAL HISTORY (DO YOU HAVE OR HAVE HAD):

____ABNORMAL PAP SMEAR
____BARTHOLIN'S GLAND CYST
____TUBAL LIGATION or ESSURE STERILIZATION
_____ENDOMETRIOSIS
_____FIBROID UTERUS
_____OVARIAN CYST
_____PARTNER WITH A VASECTOMY
_____PELVIC INFLAMMATORY DISEASE
_____POLYCYSTIC OVARIES (PCOS)
____SEXUALLY TRANSMITTED DISEASE (WHICH ONES/TYPE) _____

PAST SURGICAL/MEDICAL HISTORY **_____NONE**

____BACK SURGERY
____BLADDER INSTILLATIONS
____BLADDER HYDRO DISTENTION
____BLADDER SLINGS
____BOTOX IN BLADDER
____BOWEL/COLON RESECTION
____CARDIAC STENTS OR BYPASS
_____CLOSURE OF VAGINA
_____COLOSTOMY
_____CYSTOSCOPY
_____HEART DISEASE
_____INTERSTIM IMPLANT
_____KIDNEY SURGERY
_____UTERINE VAGINA/LIFT
____PAIN CONTROLNEUROSTIMULATOR
____REPAIR OF CYSTOCELE
____REPAIR OF RECTOCELE/ANUS
____REPAIR OF VAGINA OR ANUS
____TRANSURETHRAL BULKING
____URETHRAL DILATIONS
____BREAST SURGERY (Circle all that apply: augmentation, reduction, lumpectomy, mastectomy)
____AUGMENTED VAGINAL REPAIR (mesh or graft)
____ENDOMETRIAL ABLATION (NOVASSURE, HYDROTHERM)
____REMOVAL OF FALLOPIAN TUBES (right, left, both)
____HYSTERECTOMY (vaginal, abdominal, or above the cervix)
____REMOVAL OF UTERINE FIBROIDS W/O HYSTERECTOMY
___TUBAL REVERSAL (RESTORATION OF FERTILITY)
___REMOVAL OF OVARIES (right, left, both)
____ORTHOPEDIC SURGERY: PLEASE LIST_____
____PRIOR BLADDER MEDICATIONS: PLEASE LIST_____
____ANY TREATMENT FOR FECAL INCONTINENCE:_____
____OTHER SURGERIES_____

FAMILY HISTORY

____BLEEDING/CLOTTING DISORDERS
____BRCA ABNORMALITIES
____BREAST CANCER:PLEASE LIST WHO_____
____OVARIAN CANCER: PLEASE LIST WHO_____

LIST CURRENT INTERNIST, CARDIOLOGIST OR PULMONOLOGIST:_____

_____

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Consent for Purpose of Treatment, Payment or Health Care Operations And Medical Information Release

I consent to the use or disclosure of my protected health information by Florida Bladder Institute (FBI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of FBI. I understand that diagnosis or treatment of me by FBI may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. FBI is not required to agree to the restrictions that I may request. However, if FBI agrees to a restriction that I request, the restriction is binding on FBI practice. I have the right to revoke this Consent, in writing, at any time, except to the extent that FBI practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information is information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Notice of Privacy Practices for FBI prior to signing this document. Notice of Privacy Practices for FBI has been provided to me.

The Notice of Privacy Practices for FBI practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of FBI health care operations.

A summary of the Notice of Privacy Practices for FBI is also posted in the waiting room.

This Notice of Privacy Practices for FBI also describes my rights and the duties of FBI practice with respect to my protected health information.

FBI reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for FBI. I may obtain a revised Notice of Privacy Practices for FBI by contacting the office of FBI at 1890 SW Health Parkway, Suite 205, Naples, FL 34109 or by calling (239) 449-7979.

Release of Medical Information: If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of information each person may receive by checking the items we may release.

Name	Relationship	Type of information which may be released		
_____	_____	____All Info	____Appts Only	____Billing
_____	_____	____All Info	____Appts Only	____Billing
_____	_____	____All Info	____Appts Only	____Billing

_____ **No Information to Be Released**

Name of Patient / Representative (Please Print):_____Date: _____

Signature of Patient or Representative: _____Employee Initials:_____

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Financial Information

As a courtesy to you, we will be happy to bill your insurance company for services rendered. If for any reason your insurance company denies the claim, you will be personally responsible for the charges. A credit card is **required** to be kept on file for any charges not covered by insurance. Due to the thousands of insurance plans available it is impossible for us to know the coverage details of all of the policies. It is your responsibility to know what type of coverage, benefits, deductibles and co-payments you have with your insurance plan.

Well Woman Exam: Most insurance companies do not cover more than one routine well woman exam per 365 day period. If you have had this service provided by another provider within the last 365 days you will be responsible for paying for today's visit.

Pathology Notice: Certain tests that you have done in the office will be sent to a pathologist for diagnostic evaluation. The pathologist will submit a bill to your insurance company and bill you directly if there is a balance due.

Phone Calls: We encourage you to use the patient portal* to communicate with your provider concerning health questions. Communication through the patient portal is more efficient and does *not* incur a charge to you. Phone calls regarding health concerns *will* incur a charge. The charge will vary from **$30** to **$90** depending on the length of the call.

Surgery Cancellation Policy: A fee of **$500.00** will be charged if you cancel a scheduled surgical procedure with less than a 30 day notice.

No Show and Late Arrival Policy: A fee of **$50.00** will be charged for Consecutive "No Show" Appointments. Subsequent occurrences may results in dismissal from the practice. If you are more than **10 minutes late**, the appointment will be rescheduled.

Assignment to Pay for Services: I agree to pay the Florida Bladder Institute & Especially for Women for all charges for services rendered today, or any future date of service, in this office. I understand that any unpaid charges will be billed to my credit card. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney's fees and/or court costs.

I agree with all of the statements above.

_____ _____

Signature of Patient or Responsible Party Date

***Make Appointments, Send Messages, Access Your Health Records & See Your Billing Statements 24 Hours A Day On The Patient Portal Found On Our Website WWW.FLORIDABLADDERINSTITUTE.COM**

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In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show and Late Arrival Policies as follows.

Effective May 1, 2017 we will implement a "no-show" policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence – Patient will receive a letter advising of our policy.
- Second occurrence – Patient will receive a 2nd letter and a $50.00 no show fee assessment
- Third and subsequent occurrences – May result in dismissal from practice and additional $50 no show fee

If a patient is more than **10** minutes late for an appointment, the appointment will be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

New patients are encouraged to log on to the patient portal and fill out Demographics and Medical History prior to coming in. Otherwise, new patients are required to arrive at the office **30** minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time or even reschedule your appointment.

Thank you,
Florida Bladder Institute and Especially for Women

Signature: _____ Date _____