**NORTH DALLAS UROGYNECOLOGY, PLLC OFFICE POLICIES**

Thank you for choosing North Dallas Urogynecology, PLLC and Dr. Aimee Nguyen for your medical care!

**GENERAL OFFICE POLICIES:**

Appointments: Patients are seen by appointment only. We try our best to run on time. Therefore, if you are more than 15 minutes late, it is up to the discretion of the doctor whether we will be able to see you at your time slot. You may be asked to reschedule.

We call one to two days in advance for appointment reminders. This allows us to see all the patients who have requested appointment times that day. Thus, we do request that you cancel your appointment 24 hours in advance, or you may be billed $25.

Office Hours: Our office hours are 8:30 A.M. to 4:30 P.M. Monday through Friday, and we are closed from noon to 1pm for lunch. Dr. Nguyen or a covering physician is available 24 hours a day for urgent situations.

Terminating Relationship: Unfortunately, it is sometimes necessary to terminate the patient/

physician relationship. We will provide written notice of the termination and comply with regulations stipulated by the Texas Medical Board.

**FINANCIAL POLICIES:**

Insurance Cards**:** You will be asked to present your insurance card at every visit. Although this might be inconvenient, it is necessary. Insurance plans and ID numbers are changing in order to keep social security

numbers off the ID card.

Benefits**:** Insurance benefits can be very confusing. Each company has many different types of policies. Our office will try to help you as best we can. However, ultimately, it is your responsibility to know your benefits, including limitations and exclusions, as you are responsible for payment. If you have any questions regarding any of this, including covered services, deductibles, maximum benefits, please contact the insurance administrator of your employer or your insurance company.

New Insurance: If you have new insurance, please let us know at the time you schedule an appointment in order that we can verify benefits prior to your appointment. If we are unable to verify, you will be responsible for the total allowable charges. When your insurance company does pay, we will refund your overpayment.

Co-Pay**:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address multiple problems during a physical exam or at the same time you have a procedure scheduled.

HMO/POS**:** You are required to be directed/referred by your **P**rimary **C**are **P**hysician (PCP) that you have selected or been assigned to by your insurance company before your appointment with Dr. Nguyen. If you have not done this, your insurance will not pay for your visit and you would be responsible for payment in full.

Insurance payments: We will sometimes ask your assistance to get the insurance company to pay the submitted charges. If they request some information from you, it is extremely important that you get them the information they request in a prompt manner. Always keep a copy of what you send them, along with the person’s name to send it to. Please follow up with that person within 24 hours to verify that they have received the information you sent and will be processing your claims. Ultimately, it is your responsibility for payment of the services provided.

Responsible Party: The patient being a child or minor, the parent or guardian bringing the child to the appointment is responsible for all co-payments, co-insurances, and outstanding balances. We will provide a receipt of payment in order that retrieval for payment can be refunded to the paying parent.

Self Pay**:** Payment is required in full at the time of service.

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**TREATMENT:**

Your treatment will be based on medical necessity. Some procedures and labs may not be covered under

your particular plan. It is not our responsibility to verify that everything is covered before treatment is provided.

Medication**:** We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a very high co-pay, we would need to be provided with alternatives that are financially acceptable to you.

Refills**:** Please plan ahead for your prescription refills. If your prescription says no refills, please call your pharmacy. They will process an electronic or fax request to us. We need at least 24 hours notice to process the authorization.

Referrals**:** Sometimes it is necessary for you to obtain a referral authorization from your primary care physician in order to see a specialist for the patient’s condition. Please verify that your primary care physician has obtained a referral authorization and you receive documentation of that authorization. We can schedule the patient without documentation of the referral authorization but the physician will not be able to treat the patient without documentation of the referral authorization from the primary care physician. Most primary care physician requires at least 48 hours to process the referral authorization.

**MEDICAL RECORDS AND FORMS:**

Our office follows the rules set forth by the Texas Medical Board when preparing and furnishing medical records. A $25.00 charge for the first twenty pages and $.50 per page for every copy thereafter is what they consider to be a reasonable fee. This fee includes the cost of copying and postage. Payment must be made prior to the release of the records. We ask that you allow 15 business days to process this from the date of the written request.

Copies of diagnostic tests or immunization records only will be provided at no charge with 48 hours notice.

If you require a form or a letter to be completed by the physician (other than excuse notes), a 48 hours notice is required. There will be a $25.00 charge for this service.

Thank you for choosing North Dallas Urogynecology, PLLC. Please let the receptionist know if you would like a copy of this for your records.

Patient/Legal Guardian Signature Date

Print Name

**PATIENT TESTIMONIAL CONSENT**

By signing below, you are consenting to Dr. Aimee Nguyen’s use and disclosure of the information in your testimonial and acknowledgement that the testimonial and acknowledgement that the testimonial may be used, all or in part, in our advertising, publications, website, ect. both now and in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Signature Date

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North Dallas Urogynecology

**HIPPA Disclosure**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate

in your medical record at North Dallas Urogynecology, or may be received from outside health entities and filed in your medical record. I understand that this information can and will be used by North Dallas Urogynecology to (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may

be involved in the treatment directly and indirectly (b) Obtain payment from third-party payers (c) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 4401 N. Coit Rd, Ste 305 Frisco, TX

75035. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature Date

Release of Information Authorization

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: Release of Information to Spouse:

Spouse’s Name:

Yes No

Yes No

Release of Information to Other Individual:

Name & Relationship: Phone #:

Yes No

Preferences

I prefer to be contacted in the following manner: Phone#: ( )

 Leave message with detailed information.

 Leave message with contact number only.

 Do Not leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature Date Parent/Guardian

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**Patient Demographics**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | | Date of birth | | | | | | Age |
| Address City State Zip | | | | | | | | | | |
| Home Phone | | Work Phone | | | | | | Cell Phone | | |
| Social Security # | | | | | Marital Status: M S W D | | | | | |
| Race | Language | | | | | | E-mail Address: | | | |
| **Emergency Information** | | | | | | | | | | |
| Emergency Contact Name | | | | | | Relationship | | | | |
| Emergency Contact Home Phone | | | Work Phone | | | | | | Cell Phone | |
| **Pharmacy Information** | | | | | | | | | | |
| Pharmacy Name Address Phone Number | | | | | | | | | | |
| Patient Employer Information | | | | | Spouse's Information | | | | | |
| Patient's Employer | | | | | Spouse's Name | | | | | |
| Occupation | | | | | Spouse's Employer | | | | | |
| **Primary Insurance Information** | | | | | | | | | | |
| Name of Primary Insurance | | | | | Insurance ID # | | | | | |
| Subscriber's Name | | | | | Group # | | | | | |
| Subscriber Date of birth | | | | | Co-Pay $ Prescription Plan: Yes No | | | | | |
| **Secondary Insurance Information** | | | | | | | | | | |
| Name of Secondary Insurance | | | | | Insurance ID # | | | | | |
| Subscriber's Name | | | | | Group # | | | | | |
| Subcriber's Date of Birth | | | | | Co-Pay $ Prescription Plan: Yes No | | | | | |

**Insurance Authorization and Assignment**

I authorize North Dallas Urogynecology, PLLC to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for release services. I authorize the payment of all benefits to North Dallas Urogynecology, PLLC.

I understand that I am ultimately responsible for all services whether covered by insurance or not. I authorize my physician, based

on his/her discretion, to access my chart for utilization management review and to view my prescription history from external sources.

Date Signature

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North Dallas Urogynecology

Female Pelvic Medicine and Reconstructive Surgery

MEDICAL HISTORY QUESTIONNAIRE

Name:

Age:

Date:\_

Primary Care Physician: Gynecologist:

Name: Address:\_

Phone: \_

\_ Name: Address:\_

\_

Phone: \_

Name of previous Urologist (if applicable):

Whom may we thank for referring you to us? \_\_

Please describe ‘in your own words the nature of your gyne or urologic problems’:

When did you first become aware of the problem?\_

Describe any previous treatments (medicines, surgery, etc) prior to this visit:

**Allergies**: Do you have any drug allergies? Y N

If yes, please include name of drug or xray dyes and **describe the type of allergic reaction**:

**Medical History:**

As an Adult have you had (please circle):

Heart Disease High Cholesterol Reflux/GERD Depression

High Blood Pressure Stomach Ulcers Seizure disorder Anxiety Disorder Diabetes Kidney Disease Paralysis Psychiatric Illness Anemia Liver Disease Hepatitis B/C Glaucoma

Thyroid Disease Kidney/Bladder stones Back Problems Serious injury/Accident

Blood clots Bleeding problems Multiple Sclerosis Parkinson’s Disease

Stroke or TIAs Heart Attack Frequent Bladder Infections Abnormal pap smears Chronic cough Asthma Emphysema/COPD HIV Congestive Heart Failure Cancer, If yes, what type What type of treatment: \_ List Other medical conditions not listed above:

**Surgical History**

Have you had a hysterectomy? Y N

*If yes…For what reason?*

*…at what age?*

*What type of incision? Abdominal*

Have you had your ovaries removed? Y N

*Vaginal*

*Laparoscopic*

Have you had any surgeries for incontinence or bladder problems? Y N

*If yes…what type and what age?*

Please list any other operations you’ve had and your age at the time:

**Family & Social History**

Have any first degree relatives had these diseases? If so, please indicate their relationship to you.

High blood pressure Stroke Cancer (please list type) Breast Cancer Blood/Clotting Disorder Urinary Incontinence

Heart Disease Diabetes Kidney Disease\_ Osteoporosis \_ Relaxation of Uterus or Vagina Ovarian Cancer

Other family or Hereditary Diseases Are you a: current smoker former smoker non- smoker

If yes… how many packs per day

Do you drink alcohol? Y N

If yes…how many drinks per week

Do you use recreational drugs? Y N Your occupation

how many years

Current marital status (circle one): Single Married Divorced Widowed

Number of pregnancies Number of miscarriages

Number of Children Number of abortions

Date of Last Menstrual Period:

**Medications:** Please list all current medications (including hormones, contraceptives, vitamin, and dosages)

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** |
|  |  |  |
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**Symptoms Review:** Please circle any symptoms you’ve had in the past few months:

|  |  |  |  |
| --- | --- | --- | --- |
| **General Symptoms** | **Hematologic/Allergy** | **Gastrointestinal** | **Cardiovascular** |
| Fever Chills | Clotting Problems | Abdominal pain | Chest pain |
| Change in appetite | Swollen Glands | Diarrhea | Shortness of Breath |
| Headache | Hay fever | Blood in stools | Varicose Veins |
| Wt loss/gain>10 lbs | Prolonged bleeding | Indigestion | Swelling of legs |

Nausea /vomiting Easy bruising Constipation/Bloating Palpitations

|  |  |  |  |
| --- | --- | --- | --- |
| **Neurological**  Memory Loss | **Endocrine**  Excessive thirst | **Musculoskeletal**  Joint pain | **ENT**  Blurred vision/visual change |
| Dizzy spells  Tingling Numbness Insomnia Tremors  Loss balance | Intolerance to hot/cold  Excessive fatigue | Back pain  Weakness | Cold  Cough  Sore throat Hearing loss Dry Eyes  Dry Mouth  History of glaucoma |
| **Skin**  Skin Rash Boils Change in -  Appearance of mole | **Respiratory** Wheezing Frequent cough Cough up blood Trouble breathing | **Gynecologic**  Breast pain or lump  Hot flashes Vaginal Bleeding Vaginal discharge | **Psychiatric**  Depressive symptoms Thoughts of suicide Anxiety  High Stress level |

Change in size of mole Difficulty Remembering

North Dallas Urogynecology

Name

Date

While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you experience, and, if so, how much are you bothered by….. | Not at all | Somewhat | Moderately | Quite a bit |
| Usually experience pain in the lower abdomen or  genital region? |  |  |  |  |
| Usually experience heaviness or pressure in the pelvic  area? |  |  |  |  |
| Usually have a bulge or something falling out that you can see or feel in the vaginal area? |  |  |  |  |
| Usually experience a feeling of incomplete bladder  emptying? |  |  |  |  |
| Feel you need to strain too hard to have a bowel  movement? |  |  |  |  |
| Feel you have not completely emptied your bowel at the end of a bowel movement? |  |  |  |  |
| Ever have to push on the vagina or around the rectum  to have or complete a bowel movement? |  |  |  |  |
| Usually lose stool beyond your control if your stool is well formed or loose? |  |  |  |  |

1) Do you leak urine with activities such as: coughing gently, coughing hard, sneezing, laughing, lifting, bending, jumping, jogging or exercise?

• If yes, how often? # times /day or # times /week. For how many years?\_\_\_\_

• Please circle which activities above that this occurs with.

• Is this socially bothersome? Yes or No

2) When you get the urge to urinate, might you lose urine before you get to the toilet in time? Yes or No

• If yes, how often? # times /day or # times /week. For how many years?\_\_\_\_

• Is this socially bothersome? Yes or No

3) How often do you typically get the urge to urinate on average?

• every 30 min to 1 hour

every 1-2 hours

• every 2-3 hours

every 3-4 hours

• Is this socially bothersome? Yes or No

4) How often do you wake up at night to urinate?

• Do you wake up at night due to urge or are you a light sleeper?

5) Do you leak urine without any warning at all? Yes or No

• If yes, how often? # Times /day or # times /week

6) Do you ever wet your bed at night when sleeping? Yes or No

• If yes, how often? # Times /day or # times /week