9195 Grant Street, Suite 410
Thornton, CO 80229
Phone: 303-280-2229
Fax: 303-280-0765
www.TCPFIC.com

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Welcome to The Colorado Pelvic Floor & Incontinence Center! We understand you have many options for healthcare providers. We are happy that you chose us! Visiting a new doctor can be an unnerving experience. We are here for you and hope to make your visit as pleasant as possible.

In order to get to know you better and eliminate some of your waiting time, we are enclosing your new patient paperwork in this packet. ***Please complete all the forms and bring them with you to your appointment. Please have your current insurance card and a photo I.D. with you (a driver's license or state-issued identification card will be sufficient).*** The enclosed checklist should help you remember everything for your appointment.

It is our policy to collect all co-payments, co-insurance, and deductibles at the time of service. If you are unable to make such payments at the time of your appointment, please call our billing department at 303-280-2229, option 3 to make financial arrangements prior to your visit. We now offer Simple Solutions, an easy way to make automatic payments on your account through your credit card. You will find the paperwork for Simple Solutions enrollment in this packet.

Our physicians make every effort to maintain a time-efficient schedule however occasionally a patient will have more questions than expected and will require extra time. And it may happen that your physician may get called out to a delivery. If the doctor is called away during your appointment time, we will do everything we can to accommodate your schedule. You may see the other physician if time permits, or you may reschedule. Your understanding is much appreciated.

The patient portal, accessed through our website, www.tcpfic.com, has options to request an appointment, and once you are established with us, request prescription refills and pay your bill. Our website also offers educational material, biographies of our physicians, and useful links. You can also find us on Facebook and Twitter.

If you ever have a concern, a question, or a compliment, please feel free to contact our office. You can call us at our main phone number, 303-280-2229 or send an email to: info@whg-pc.com.

Thank you for choosing The Colorado Pelvic Floor & Incontinence Center! We look forward to seeing you soon!

Sincerely,
**The Physicians and Staff at The Colorado Pelvic Floor & Incontinence Center**

# THE COLORADO PELVIC FLOOR AND INCONTINENCE CENTER

## PATIENT REGISTRATION

**Patient's Legal Name** ______________________________________________
Last First Middle Initial

Street Address______________________________________ Apt/Unit #______________

City________________________________ State__________ Zip Code______________

Birth Date_________ Age____ SS #__________________ Marital Status / / S / / M / / D / / Other

**Race** ______________ **Ethnicity** - Hispanic // Non-Hispanic // Decline

Home Phone____________________________ Work Phone____________________________

Mobile Phone___________________________ Email Address __________________________

**Preferred Pharmacy**______________ Address______________________PH#____________

**Responsible Party:** Name________________________ SS#__________________________

Address ________________________________________________________________
Street Apt/Unit# City State Zip Code

Work Phone_________________ Employer/Occupation____________________________

==========================================================================

**Primary Insurance**____________________________________ Type (HMO, PPO, etc.) ________

Insured's Name_____________________________ Relationship to Insured__________________

ID #_____________________ Group #________________Insured's Birth Date________________

Claims Address_________________________________________________________________

Membership Services Phone_______________________________ **Effective Date**_____________

**Secondary Insurance**__________________________________ Type (HMO, PPO, etc)__________

Insured's Name_____________________________ Relationship to Insured__________________

ID #_____________________ Group #________________Insured's Birth Date________________

Claims Address_________________________________________________________________

Membership Services Phone_______________________________ **Effective Date**_____________

==========================================================================

Emergency Contact_________________________ Relationship to patient____________________
Home Phone_______________________________ Work Phone_____________________________
**Family Physician**___________________________ Phone Number__________________________
**Referring Physician**_________________________ Phone Number __________________________
**Whom may we thank for referring you?** ______________________________________________

==========================================================================

**MEDICAL INFORMATION AUTHORIZATION:** I authorize release of any medical information necessary to process my claims.

Signed______________________________________________ Date_________________________

**ASSIGNMENT OF BENEFITS AND AGREEMENT FOR PAYMENT:** I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all no covered fees incurred within 30 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Signed______________________________________________ Date_________________________

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## Patient Questionnaire

**Patient Name**________________________________________ **DOB**__________
**Reason for visit** _______________________________________**DATE**___________
Last Annual exam: Date_______________
Last Colonoscopy: Date_______________ Result_____________________________________
Last Diabetes Screen: Date_____________ Result_____________________________________
Last Cholesterol Screen: Date__________ Result_____________________________________
Last Mammogram: Date______________ Result_____________________________________
Last Osteoporosis Screen: Date________ Result_____________________________________
Last Pap Screen: Date________________ Result_____________________________________
Last Thyroid Screen: Date_____________ Result_____________________________________

**PAST GYNECOLOGICAL HISTORY**

[ ]Birth control
Type__________
[ ]Cervical Dysplasia
[ ]Fluid in fallopian tubes
[ ]Vaginal Dysplasia
[ ]Vulvar Dysplasia

[ ]Ectopic Pregnancy
[ ]Endometriosis
[ ]Fibroids
[ ]Herpes
[ ]Infertility
[ ]Menopause

[ ]No Periods
[ ]Abnormal Bleeding
[ ]Painful Periods
[ ]Pelvic Pain
[ ]Pelvic Infection
[ ]Pelvic Mass
[ ]Pelvic Prolapse

Other______________________ ___________________________

**PAST MEDICAL HISTORY**

[ ]Abnormal Mammogram
[ ]Breast Cyst
[ ]Fibrocystic Breast Disease
[ ]Breast Discharge
[ ]Breast Mass
[ ]Breast Pain
[ ]Cancer Type______________
[ ]High Blood Pressure
[ ]High Cholesterol
[ ]Heart Palpitations
[ ]Mitral Valve Prolapse
[ ]Diabetes Type____________

[ ]Elevated Prolactin
[ ]Hyperthyroid
[ ]Hypothyroid
[ ]Metabolic Syndrome
[ ]Obesity
[ ]Polycystic Ovarian Syndrome
[ ]Lupus
[ ]Anal Fissures
[ ]Constipation
[ ]Reflux Disease/Heartburn
[ ]Hemorrhoids
[ ]Irritable Bowel Syndrome

[ ]Anemia
[ ]Blood Transfusion in past
[ ]Coagulation Disorder
[ ]Varicose Veins
[ ]Blood clot in leg/lung
[ ]VonWillibrand's Disease
[ ]Chronic Back Pain
[ ]Fibromyalgia
[ ]Osteopenia
[ ]Osteoporosis
[ ]Headaches/Migraines

[ ]Seizure Disorder
[ ]Alcohol/Drug Abuse
[ ]Anxiety Disorder
[ ]Bipolar Disorder
[ ]Depression
[ ]Other___________________ ___________________________

[ ]Seasonal Allergies
[ ]Asthma
[ ]COPD/Obstructive Bronchitis
[ ]Chronic Sinusitis

[ ]Interstitial Cystitis
[ ]Bladder urgency
[ ]Protein/Blood in Urine
[ ]Kidney/Bladder Infections
[ ]Incontinence/Loss of urine
[ ]Kidney Stones

**PAST GYNECOLOGICAL SURGERY**

[ ]Cesarean Section Number____________ Reason_____________________________
[ ]Ectopic Pregnancy Side_______________ Treatment____________________________
[ ]Hysteroscopy Date_______________ Diagnosis____________________________
[ ]Hysterectomy Date_______________ Diagnosis/Type_______________________
[ ]Ovaries Removed Reason______________________________
[ ]Laparoscopy Date_______________ Diagnosis____________________________
[ ]Prolapse/Incontinence Date_______________ Type________________________________
[ ]Sterilization Date_______________ Type________________________________

**PAST SURGERIES**

[ ]Abdominal Surgery
[ ]Ankle Surgery
[ ]Appendix
[ ]Bariatric - LapBand
[ ]Bariatric – Roux-en-Y
[ ]Bronchoscopy
[ ]Cataract Surgery
[ ]Gall Bladder Removed
[ ]Colonoscopy
[ ]Brain Surgery
[ ]Bladder Scope
[ ]Foot Surgery
[ ]Hand Surgery
[ ]Hemorrhoid Surgery
[ ]Hernia Repair
[ ]Knee Surgery
[ ]Lasik
[ ]Spine Surgery
[ ]Neck Surgery
[ ]Plastic Surgery
[ ]Shoulder Surgery
[ ]Sinus Surgery
[ ]Skin Biopsy
[ ]Skin Tag Removal
[ ]Spleen Removed
[ ]Chest Surgery
[ ]Thyroid Removed
[ ]TMJ Surgery
[ ]Tonsils/Adenoids
[ ]Hip Replacement
[ ]Knee Replacement
[ ]Other___________________
___________________

**MEDICATIONS**

TYPE DOSE DATE STARTED___________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

**ALLERGIES** _____________________________________________________________

**FAMILY HISTORY**

[ ]Breast Cancer___________
[ ]Colon Cancer____________
[ ]Kidney Cancer___________
[ ]Ovarian Cancer__________
[ ]Prostate Cancer__________
[ ]Uterine Cancer__________
[ ]Heart Disease___________
[ ]Thyroid Disease__________
[ ]Hypo [ ]Hyper
[ ]Osteoporosis
[ ]Problems w. Anesthesia
[ ]Sickle Cell Disease/Trait
[ ]Lupus
[ ]Blood Clots/Coagulation D/O
[ ]Von Willibrand's Disease
[ ]Other____________________
____________________

**GENETIC DISORDERS**

LIST ANY GENETIC DISORDERS OR SYNDROMES COMMON IN YOUR FAMILY

___________________________________________________________________________

**PAST OBSTETRICAL HISTORY**

How many times have you been pregnant? ______ How many deliveries have you had? ____

How many miscarriages? _____ Abortions? _____ Tubal pregnancy? _____

How many living children do you have? _____ How many, if any, were premature? ______

Have you had any c/sections? If yes, how many? _____

**SOCIAL HISTORY**

SUBSTANCE USE

[ ]Tobacco [ ]Current [ ]Past Amount______ Age Start______ Age Stop______

[ ]Alcohol [ ]Current [ ]Past Amount______ Age Start______ Age Stop______

[ ]Caffeine [ ]Current [ ]Past Amount______ Age Start______ Age Stop______

[ ]Street Drugs

Type__________ [ ]Current [ ]Past Amount______ Age Start______ Age Stop______

__________ [ ]Current [ ]Past Amount______ Age Start______ Age Stop______

[ ]Narcotics [ ]Current [ ]Past Amount______ Age Start______ Age Stop______

EDUCATION

[ ]High School

[ ] Did not complete High School

[ ]GED

[ ]Graduated High School

[ ]College, 2 year

[ ]College, 4 year

[ ]Graduate Studies/Degree

[ ]Post Graduate Studies/Degree

OCCUPATION

_________________________________________________________________

EXERCISE

[ ] None [ ] Active, but no formal exercise

[ ] Less than once a week [ ] 2-4 times/week [ ] greater than 4 times/week

DOMESTIC VIOLENCE [ ]History of.. [ ]Current

[ ] Emotional/Verbal [ ] Physical

[ ] Parent [ ] Spouse

MARITAL STATUS

[ ] Dating [ ] Divorced [ ] Engaged [ ] Married [ ] Non-Dating [ ] Single [ ] Widowed

Partners Name__________________________________________________________

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**NAME**______________________________________________ **DATE**____________________

**WHY ARE YOU HERE TODAY?**________________________________________________________

**Menopausal? [ ] Yes [ ] No** **Hysterectomy? [ ] Yes [ ] No**

**If NO, Date of Last Period**____________________ **Method of Contraception**____________________

***PLEASE NOTE ANY SYMPTOMS YOU HAVE RECENTLY HAD THAT YOU FEEL ARE ASSOCIATED WITH YOUR VISIT TODAY. IT IS NORMAL NOT TO HAVE MOST OF THESE SYMPTOMS.***

| | | | |
|---|---|---|---|
| **CONSTITUTIONAL** | [ ] Fatigue | [ ]Weight Loss | [ ]Weight Gain |
| | [ ]Other___________ | | |
| **EYES** | [ ]Glasses/Contacts | [ ]Other___________ | |
| **HEAD/NECK** | [ ]Sinus Congestion | [ ]Dentures | [ ]Decreased Hearing |
| | [ ]Other___________ | | |
| **BREAST** | [ ]Lumps | [ ]Tenderness | [ ]Nipple Discharge |
| | [ ]Other___________ | | |
| **CARDIOVASCULAR** | [ ]Chest Pain | [ ]Irregular Heart Beat | [ ]Fainting |
| | [ ]Other___________ | | |
| **RESPIRATORY** | [ ]Shortness of Breath | [ ]Wheezing | [ ]Cough |
| | [ ]Other___________ | | |
| **GASTROINTESTINAL** | [ ]Nausea | [ ]Vomiting | [ ]Diarrhea |
| | [ ]Constipation | [ ]Blood in Stools | [ ]Other___________ |
| **GENITOURINARY** | [ ]Urgency | [ ]Frequency | [ ] Dysuria |
| | [ ]Incontinence | [ ]Decreased Libido | [ ]Other___________ |
| **SKIN** | [ ]Rash | [ ]Changes in Moles | [ ]Changes in Lesions |
| | [ ]Other___________ | | |
| **NEUROLOGICAL** | [ ]Muscular Weakness | [ ]Incoordination | [ ]Tingling/Numbness |
| | [ ]Other___________ | | |
| **MUSCULOSKELETAL** | [ ]Joint Pain | [ ]Muscle Pain | Other_____________ |
| **ENDOCRINE** | [ ]Frequent Urination | [ ]Constant Drinking | [ ]Cold Intolerance |
| | [ ]Heat Intolerance | [ ]Other___________ | |
| **PSYCHIATRIC** | [ ]Anxiety | [ ]Depression | [ ]Difficult Sleeping |
| | [ ]Other___________ | | |
| **HEME-LYMPH** | [ ]Easy Bleeding | [ ]Easy Bruising | [ ]Lymph Node Pain |
| **ALLERGIC-IMMUNE** | [ ]Sinus Symptoms | [ ]Frequent Illness | [ ]Other___________ |

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## OFFICE FINANCIAL POLICY

Thank you for choosing The Colorado Pelvic Floor & Incontinence Center for your health needs. Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policies allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

### Insurance Plans

- It is your responsibility to keep The Colorado Pelvic Floor & Incontinence Center up to date with your correct insurance information. **If the insurance company you designate in incorrect, you will be responsible for payment for the visit.**
- We must emphasize that, as your medical provider, our relationship is with you, not your insurance company. As a courtesy, we file your medical claim to your insurance at no charge.
- According to your insurance plan, you are responsible for any and all copayments, deductibles, and co-insurances. We do ask that you pay all co-pays, deductibles, and non-covered charges the day of your service.
- WHG calls and verifies benefits for surgical procedures and obstetrics. However, it is still the patient's responsibility to know their benefits and we encourage you to contact your insurance as well.
- WHG will keep a confidential credit/debit card on file with us. This information is stored in a secure system that complies with Payment Card Industry Data Security Standard. You will have the option to have balances automatically run (for your convenience) or be contacted by the Billing Department prior to running your card for unpaid balances.
- Please always feel free to contact our Billing Department with any concerns, questions, or information regarding your account.

### Self-Pay

If you do not have insurance, self-pay patients will be expected to pay at the time of service. Surgical procedures and pelvic treatment will be discussed with the patient for payment prior to the procedure being performed.

## OFFICE POLICIES

### After-Hour Emergencies:

If you should experience a life-threatening emergency, please call 911 or go to the closest emergency room. If you have other after-hours emergencies, you may contact the physician on-call by call our main number. This service is for emergency or potential emergency care only. Please call during regular business hours for non-urgent questions or concerns.

## After-Hours Narcotics

There will be no refills of any narcotic after hours or on weekends. Please call during our regular business hours.

## Late Appointment Arrival

We ask that all patients arrive at the designated time. If you do arrive late for your appointment, we may need to see other patients before we can see you. In addition, if you are more than 15 minutes late, you may be asked to reschedule.

## Cancellations and No-Shows

As a courtesy to other patients, we request that you notify TCPFIC as soon as possible if you need to change your appointment. This allows us to offer that appointment time to another patient.
We understand that sometimes unforeseen circumstances may arise on the day of your appointment. But we ask you give notice as soon as possible (24 hours if possible) if you will not be able to make your appointment. If you have missed your appointments 3 times and have not cancelled or rescheduled, you may be dismissed from our practice.

**The Colorado Pelvic Floor & Incontinence Center strives to offer you the very best medical care; therefore, we have implemented these policies to continue providing premium care to all of our patients.**

**I have read and understand the Financial/Office Policies:**

_______________________________________________ _______________________

**Patient/Responsibility Party Signature** **Date**

_______________________________________________ ______________________

**Print Patient Name** **Date of Birth**

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## Secure Credit Card FAQ

1) Why do you have a credit card on file?
   This is a convenience for our patients and a policy we have implemented to streamline patient billing.

2) When will my card be charged?
   a) We bill your insurance.
   b) Then we bill you how you request: credit card, debit card, cash, or check.
   c) We bill when it's convenient for you: online through our patient portal at www.whg-pc.com, when you call us with your consent, at each appointment, on a specific day of each month, or by mailed statements.
   d) If three statements are unpaid and we are unable to contact you, your credit card on file will be charged.
   e) We will send any unpaid accounts to collections.

3) When would I be billed if I don't choose one of the options?
   If you don't choose an option, and do not pay three months' statements that are mailed to you after your insurance payments are received, we will call you to make arrangements. If we are unable to contact you after five days, we will bill your credit card.

4) Does your staff have access to my credit card?
   No. The credit card information is secured to the highest standard, DSS PCI compliant. You may learn about this level of security by visiting Auth.net.

5) Can you accept a debit card?
   Yes.

6) Can you accept American Express?
   Yes.

7) How often do I need to provide my credit card information?
   Annually or whenever your card information changes, i.e.; card number, expiration date, or card type.

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# *SIMPLE SOLUTIONS*

I, ________________________________ authorize The Colorado Pelvic Floor & Incontinence Center to charge my credit card for payments due including my co-pays, co-insurance, deductible, non-covered charges *and* charges billed but not paid by my insurance company. I understand the process is:

- TCPFIC will bill my insurance and wait for insurance to pay.
- TCPFIC will then send me 2 statements over a 60 day period (I have the option to pay by check, credit card, cash, etc.)
- If no payment is received in 60 days, TCPFIC will attempt to contact me to arrange for payment.
- If TCPFIC does not receive a response after mailed statements, phone calls, and/or emails, the "Patient Responsibility Amount" shown on my Statement/Explanation of Benefits (EOB), will be transferred to my credit card as listed below.

Options:

Process my credit card automatically.
I prefer a courtesy call (phone) ____________ or (email) ___________________ to alert me to the processing date of the credit card.

**I understand that The Colorado Pelvic Floor & Incontinence Center will submit my claims to the insurance company as a courtesy, but timely payment to my account is my responsibility**.

I assign my insurance benefits to The Colorado Pelvic Floor & Incontinence Center. I authorize The Colorado Pelvic Floor & Incontinence Center to maintain my credit card information on file for *SIMPLE SOLUTIONS* purposes only

___________________________________________________________ ______________
Cardholder signature Date

**This form will be renewed annually and upon expiration of credit card**

Patient Name_______________________________________________Phone:__________________

Cardholder Name (Please Print) _____________________________________________________

Cardholder Address (Please Print) ___________________________________________________

City, State, Zip (Please Print) _______________________________________________________

Circle one: Visa MasterCard Discover HSA (Health Savings Account)

Credit Card Number________________________________Exp. Date: ______

Office use only:
Account Number_______________Date Entered__________________Approved_____Declined_____Initials_________

**APPOINTMENT CHECKLIST**

___ Forms (filled out completely)
___ Insurance card
___ Photo I.D. (Driver's license or other state-issued identification card)
___Co-payment (cash, check, credit card)
___Simple Solutions paperwork

*******************************************************************************

**QUESTIONS I WANT TO REMEMBER TO ASK THE DOCTOR:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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## PATIENT HIPAA QUESTIONNAIRE AND ACKNOWLEDGEMENT

I have received a copy of The Colorado Pelvic Floor & Incontinence Center Notice of Privacy Practices.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

   Name:____________________________ Phone:____________________________

   Name:____________________________ Phone:____________________________

2. Please list the family members or significant others, if any whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name:____________________________ Phone:____________________________

   Name:____________________________ Phone:____________________________

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

   ____________________________________________________________________________

   ____________________________________________________________________________

4. Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information if other than your home phone number:

   (______)____________________________

   a. I am fully aware that a cell phone is not a secure and private line.
   b. I am fully aware my health information can be transmitted by facsimile (fax), mail, email, or the internet.

5. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail?

   YES__________ NO__________

PATIENT NAME_______________________________________________

PATIENT SIGNATURE__________________________________________

DATE____________________________________