CENTER FOR ADULT PELVIC HEALTH & CONTINENCE CARE

500 Red Creek Drive - Building 500 - Suite 120
Rochester New York 14623
Telephone (585)487-3400 Fax (585) 334-3327
Website: Pelvichealth.urmc.edu

Dear Ms. _____,

Welcome to our practice. Your appointment is _____ @ _____AM/PM

( )Dr. Gunhilde Buchsbaum ( )Dr. Paula Doyle ( )Dr. Erin Duecy ( )Dr. Lioudmila Lipetskaia ( )Pam Wigent, NP

The Medical Team - We are committed to the education of both our patients and the medical community and are proud to be a part of the University of Rochester Medical Faculty. Members of our team – our doctors, nurse practitioners, fellows and senior residents, routinely participate in the care provided in our office.

►► BEFORE YOUR VISIT ◄◄

► Complete the 2-day voiding journal well in advance of your scheduled visit. This document is necessary for your evaluation, even if you do not have symptoms of urinary leakage. Failure to complete this diary may result in additional visits and may delay treatment.

► Please do NOT empty your bladder within 1 hour of your appointment.

► Please bring the entire packet to your visit including your insurance card (DO NOT MAIL)

Insurance - We accept most major insurances in the Rochester area, but do not participate with all insurances. Please contact your referring physician and/or insurance company to determine if a referral is required. Your deductible or co-payment fee is determined by your insurance company.

Payments - This fee is determined by your insurance company. Please review and sign the "Strong Patient Care Agreement" on the next page. As per your insurance contract, co-pays are expected at the time of your visit. We accept exact amount cash, checks, MasterCard and Visa.

Late Arrivals/Cancellations -If you arrive late for your appointment, you may be rescheduled. We respectfully ask a minimum 24 hour prior notice to cancel an appointment. If you cannot keep an appointment, please notify the office as soon as possible to allow another patient to be seen. Should you not notify us of a cancellation, a $50 charge may be applied.

Directions to our office: A map with written directions is enclosed. PLEASE allow extra time if you are unsure of our location. Please feel free to contact us ahead of time if you have any questions about our location. LATE ARRIVALS MAY RESULT IN RESCHEDULING.

We look forward to participating in your medical care. Please contact our office if you have any questions or concerns.

STRONG MEMORIAL HOSPITAL
("STRONG")
PATIENT CARE AGREEMENT
SMH 660 MR

20

☐ Inpatient
☐ Outpatient
☐ ED

By signing below, I agree to the following for all care provided by Strong or by my treating professionals:

1. **Treatment Authorization.** If I am the patient, I consent to procedures and care my treating professionals recommend for me. If I am signing for a patient who is unable to consent, I consent to procedures and care the patient's professionals recommend. If asked, I will document that I am authorized to consent for the patient.
2. **Release of Medical Information.** Strong Memorial Hospital and URMC professionals may use and disclose patient health information for treatment, payment and health care operations. I authorize release of this information to government agencies (such as Medicare and Medicaid), insurance carriers, health plans, utilization review agents, home care, assisted living, nursing homes and primary care providers.
3. **Financial Responsibility.** I will pay for all hospital and professional care provided. If the bill is not timely paid I will be liable for collection fees, legal fees, court costs and interest.
4. **Third Party Payors.** I will promptly provide information about potential insurance. This includes health plans, workers compensation, no-fault and liability insurance. I authorize Strong Memorial Hospital and URMC professionals to bill payors for all care provided. If Strong or a URMC professional misses a claim submission deadline because I did not provide timely information, I will pay for the care even if it would have been covered.
5. **Medicaid and Other Assistance.** If I cannot pay, Strong's financial counselors may help me qualify for Medicaid or other assistance. I will assist with the application and provide needed information. My application may be denied if I do not provide needed information in time.
6. **Charity Care.** Strong has a Charity Care program for eligible persons who do not have insurance or cannot pay their bills. To be considered for Charity Care, I may need to apply for Medicaid and meet other requirements. (Call (585) 784-8889 for more information).
7. **No Fault Assignment.** I HEREBY ASSIGN TO URMC AND STRONG MEMORIAL HOSPITAL ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW. THIS AGREEMENT SHALL BECOME NULL AND VOID IF AT ANY TIME IT IS DETERMINED THAT BENEFITS ARE NOT PAYABLE DUE TO THE FOLLOWING CIRCUMSTANCES: LACK OF COVERAGE, VIOLATION OF A POLICY CONDITION, OR DETERMINATION THAT THE TREATMENTS/SERVICES RENDERED ARE NOT RELATED TO SAID MOTOR VEHICLE ACCIDENT. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSIBLE CHARGES UNDER SAID ARTICLE 51. URMC AND STRONG CERTIFY THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE INJURED PARTY AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE INJURED PARTY FOR SERVICES PROVIDED DUE TO INJURIES SUSTAINED IN RELATION TO THE AUTOMOBILE ACCIDENT
8. **Cost Estimates.** Estimated cost of care can be obtained by calling (585) 758-7801 or (585) 758-7650. Hospital professionals and staff are not authorized to quote the cost of care or to negotiate rates.
9. **Personal Belongings.** Strong and URMC professionals are not responsible for damage or loss to personal belongings
10. **Patient Rights.** If I am admitted, I will receive information about my rights as an inpatient.
11. **Discharge.** I will cooperate fully with Strong's efforts to arrange a safe and timely discharge. I will provide needed financial and personal information required for discharge planning and will apply for Medicaid or other assistance needed to pay for post hospital care and to facilitate discharge.

Signature	Date	Relationship to Patient (Parent, Guardian, Spouse, Self, etc)

TO BE COMPLETED BY STAFF

No signature was obtained due to:
☐ Patient's condition/capacity
☐ No representative
☐ Refused to sign

Health Care Directives:
☐ Health Care Proxy
☐ Living Will
☐ DNR/MOLST
☐ None ☐ Unknown

Health Care Agent Name: _____

Health Care Agent Telephone No.: _____

UR MEDICINE | STRONG MEMORIAL HOSPITAL

RR DONNELLEY

AMBULATORY CARE
INVOLVEMENT IN CARE DISCUSSIONS FORM
(Reference HIPAA Policy 0P23.2)

This is a worksheet to facilitate communication with the patient and with those whom the patient identifies as being involved in their care. It does **NOT** require the patient's signature. It is not meant to replace or be used instead of the SH48 Authorization for Release of Medical Information (required for release of copies of medical records). Those named on the form below are not permitted to access the patient's medical record.

The information should be entered in an **FYI Flag for Involvement in Care** in eRecord.

****DO NOT SCAN** this document into eRecord **

Patient Name: _____ Medical Record #: _____

URM & Affiliates University of Rochester Urogynecology (department, provider or practice name) may verbally discuss protected health information, including lab/test results and payment issues with the following people:

Name	Relationship	Contact Info/Comments

COMMUNICATION REQUESTS: **Date:** _____

Y	N		
		Phone me using the following number:	(#) _____
[]	[]	May phone at work	(#) _____
[]	[]	May leave messages on answering machine	
[]	[]	Other: _____	

This will remain in effect until notified differently by the above patient.

Division of Urogynecology and Reconstructive Pelvic Surgery
Pelvic Health and Continence Specialties
500 Red Creek Dr. Suite 120
Rochester, New York 14623

UR MEDICINE
Medicine of the Highest Order

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Erin E. Duecy, MD
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Lioudmila, V. Lipetskaia, MD
Pam J. Wigent, NP

Research Information

Research helps improve health care. In collaboration with our patients, we strive for superior medical care supported by scientific study.

During the course of your care, you may be approached to participate in a research study. You will have the opportunity to accept or to decline participation in any of these studies at any time.

Signing this form will ONLY give us permission to contact you about opportunities. We may do so either in clinic, by mail, or over the phone.

Thank you for helping to improve medical knowledge and patient care.

_____ _____
Patient name (please print) Patient's Date of Birth

_____ _____
Patient's Signature Date Signed

PLACE PATIENT LABEL HERE

UROGYNECOLOGY: PATIENT INTAKE FORM

Primary Care MD _____ GYN MD _____

Referred by: ( ) Primary ( ) GYN ( ) Other _____

Why are you coming for this evaluation? _____

How long have you had this problem? _____

What treatments have you tried? _____

MEDICAL HISTORY: *Number of*: Pregnancies _____ Vaginal Deliveries _____ C-Sections _____

	Medical Problems	Please check one:		
		Current problem	Past Problem	Never a problem
RESP	Asthma			
	Chronic cough			
	Chronic Obstructive Pulmonary Disease (COPD)			
HEME	Blood clot in leg or arm			
	Blood clot in lung			
	Blood disorder- **circle specific problem** *chronic anemia, von Willebrand's disease, sickle cell trait/disease, thalasemia, hemophilia*			
CARDIAC	Heart Disease- **circle specific problem** *heart attack, coronary artery disease, angina, congestive heart failure, stent placement*			
	Heart Condition- **circle specific problem** *abnormal beats or rhythm, murmur, pacemaker, artificial valves*			
	High Blood Pressure			
	Stroke			
	Transient Ischemic Attack (TIA)			
ENDO	Diabetes - **circle specific treatment** *diet-controlled, oral medications, insulin shots*			
	Thyroid Disease- **circle one:** *hypo- or hyper-*			
GU	Kidney Disease- **circle specific problem** *polycystic kidneys, renal insufficiency, renal failure (on dialysis), anatomic abnormality of kidneys or ureters*			
	Kidney Stones			
	Recurrent Bladder Infections (UTI)- *> 3/year*			
	Interstitial Cystitis			
	Abnormal Pap Smear- **year:** _____			

	Medical problems, continued	Current	Past	Never
GI	Irritable Bowel Syndrome- **circle type** *diarrhea-predominant, constipation-predominant, mixed*			
	Chronic constipation			
	Acid Reflux/chronic heartburn			
	Liver disease- **type:** _____			
MSK	Arthritis- **circle type** *osteo-, rheumatoid, psoriatic*			
	Fibromyalgia			
NEURO	Epilepsy/Seizure Disorder			
	Parkinson's Disease			
	Multiple Sclerosis			
PSYCH	Depression			
	Anxiety			
	Cognitive Impairment or Dementia			
OTHER	Glaucoma- **circle type:** *wide/open or narrow/closed*			
	Chronic Pain- Location: _____			
	Cancer- **circle type** *breast, cervical, endometrial/uterine, ovarian, bladder, kidney, other:* _____			
	Other: _____			
	Other: _____			

SURGICAL HISTORY:

Please list all past surgeries. I f you need more room, please list all surgeries on a separate sheet and attach to this packet.

Hysterectomy? □ no □ yes: year _____ *Route-* □ *abdominal incision* □ *laparoscopic* □ *vaginal*

Removal of ovaries? □ no □ yes: □ *both* □ *right* □ *left*

Year	Type of Surgery	Surgeon/Hospital	Complications

SOCIAL HISTORY:

Do you...	No	Past Use	Yes	
Use tobacco?		quit date: _____		# packs per day: _____ # years of use: _____
Use recreational drugs?		quit date: _____		Type: _____ How often? _____
Drink alcohol?		quit date: _____		Type: _____ # drinks per week: _____

Occupation: _____ □ retired □ disabled

Are you currently sexually active? □ no □ yes

Have you been sexually abused? □ no □ yes: □ *as a child* □ *as an adult* □ *currently*

Have you been physically abused? □ no □ yes: □ *as a child* □ *as an adult* □ *currently*

Are you a primary caregiver to someone? □ no □ yes: *relationship:* _____

Marital/Relationship status □ married □ single □ divorced □ separated □ other: _____

Who do you live with? □ alone □ spouse/significant other □ family □ other: _____

What is your usual level of physical activity?

□ very active & exercise regularly □ active □ a little active □ not active

What is your current mobility level?

□ walk without any problems or assistive devices □ need a cane or walker

□ need help getting on an exam table □ use a wheelchair

FAMILY HISTORY: ☐ check here if you are adopted and do not have this information

Has anyone in your family (blood relative) been diagnosed with any of the following?

Medical Problem	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Father	Mother	Brother	Sister	Other
Bleeding or clotting problem *(von Willebrands, hemophilia, platelet disorder, Factor V Leiden)*									
Breast Cancer									
Colon or Rectal Cancer									
Diabetes									
Endometrial or Uterine Cancer									
Heart Attack									
Heart Disease									
Ovarian Cancer									
Stroke or TIA									
Other: _____									
Other: _____									

REVIEW OF SYSTEMS: Circle any of the following symptoms you are currently experiencing:

Constitutional	fever · chills · weight loss · weight gain · malaise/fatigue · sweating · night sweats · weakness
Skin	rash · itching
HENT	headaches · hearing loss · ringing in ears · ear pain · ear discharge · nosebleeds · congestion · sore throat
Eyes	blurry vision · double vision · pain with light in eyes · eye pain · eye discharge · eye redness
Cardiovascular	chest pain · palpitations · shortness of breath with lying down · leg pain with walking · leg swelling · waking up at night short of breath
Respiratory	cough · coughing up blood · productive cough · shortness of breath · wheezing
GI	heartburn · nausea/vomiting · abdominal pain · diarrhea · constipation · blood in stool · dark, tarry stools · bloating
MSK	muscle pain/aches · neck pain · back pain · joint pain · frequent falls
Endo/Heme/Imm	easy bruising/bleeding · allergies · feeling too thirsty
Neuro	dizziness · tingling/numbness · tremor · change in sensation · change in speech · weakness in one arm or leg · seizures · passing out/fainting
Psych	depression · suicidal ideas · substance abuse · hallucinations · anxiety · insomnia · memory loss

UROGYNECOLOGY:

Were you treated for 3 or more bladder infections in the last year? ☐ no ☐ yes

Do you have difficulty emptying your bladder? ☐ no ☐ yes

Do you have pain when you urinate? ☐ no ☐ yes

How many times do you get up to empty your bladder at night?

☐ *0 /rarely* ☐ *1-2* ☐ *3-4* ☐ *5 or more*

How often do you have bowel movements?

☐ *daily* ☐ *every other day* ☐ *1-2 times a week* ☐ *less than once per week*

Do you leak stool? ☐ no ☐ yes: ☐ *liquid stool* ☐ *loose stool* ☐ *soft stool* ☐ *formed stool*

If you experience **URINARY INCONTINENCE**: Do you ...

Usually have an urge to urinate before you leak urine? ☐ no ☐ yes

Leak urine or rush to the bathroom when you see/feel/hear running water? ☐ no ☐ yes

Leak urine or rush to the bathroom when you approach your home after being out? ☐ no ☐ yes

Leak urine when you cough, sneeze, laugh, or exercise? ☐ no ☐ yes

Wet the bed when you are completely asleep? ☐ no ☐ yes

Feel like you leak urine constantly? ☐ no ☐ yes

Wear pads to protect your clothing from leakage of urine? ☐ no ☐ yes

If you do wear pads: What kind? ☐ pantiliner ☐ thin pad ☐ thick pad ☐ diaper

Pelvic Floor Disability Index (PFDI-20)

Instructions: Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder, or pelvic symptoms and, if you do, **how much they bother you**. Answer these by circling the appropriate number. While answering these questions, please consider your symptoms over the last 3 months. The PFDI-20 has 20 items and 3 scales of your symptoms. All items use the following format with a response scale from 0 to 4.

Symptom scale:
0 = not present
1= not at all
2 = somewhat
3 = moderately
4 = quite a bit

Pelvic Organ prolapse Distress Inventory 6 (POPDI-6)

Do You...	NO	YES
1. Usually experience pressure in the lower abdomen?	0	1 2 3 4
2. Usually experience heaviness or dullness in the pelvic area?	0	1 2 3 4
3. Usually have a bulge or something falling out that you can see or feel in your vaginal area?	0	1 2 3 4
4. Ever have to push on the vagina or around the rectum to have or complete a bowel movement?	0	1 2 3 4
5. Usually experience a feeling of incomplete bladder emptying?	0	1 2 3 4
6. Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	0	1 2 3 4

Colorectal-Anal distress Inventory 8 (CRAD-8)

Do You...	NO	YES
7. Feel you need to strain too hard to have a bowel movement?	0	1 2 3 4
8. Feel you have not completely emptied your bowels at the end of a bowel movement?	0	1 2 3 4
9. Usually lose stool beyond your control if your stool is well formed?	0	1 2 3 4
10. Usually lose stool beyond your control if your stool is loose?	0	1 2 3 4
11. Usually lose gas from the rectum beyond your control?	0	1 2 3 4
12. Usually have pain when you pass your stool?	0	1 2 3 4
13. Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	0	1 2 3 4
14. Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	0	1 2 3 4

Urinary distress Inventory 6 (UDI-6)

Do You...	NO	YES
15. Usually experience frequent urination?	0	1 2 3 4
16. Usually experience urine leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom?	0	1 2 3 4
17. Usually experience urine leakage related to coughing, sneezing or laughing?	0	1 2 3 4
18. Usually experience small amounts of urine leakage (that is, drops)?	0	1 2 3 4
19. Usually experience difficulty emptying your bladder?	0	1 2 3 4
20. Usually experience pain or discomfort in the lower abdomen or genital region?	0	1 2 3 4

Scoring the PFDI-20

Scale Scores: Obtain the mean value of all of the answered items within the corresponding scale (possible value 0 to 4) and then multiply by 25 to obtain the scale score (range 0 to 100). Missing items are dealt with by using the mean from answered items only