

Atlanta Urogynecology Associates

Dear Patient,

This packet contains information regarding both you and your visit. It is divided into 4 sections.

Section I contains an appointment card, driving directions on how to locate our office, as well as hotel information in case you are not from the Atlanta area.

Section II is your ***Patient Registration Information***. It is very important that you complete this section and ***return it to our office ASAP***. Since it is very important that we receive this information back ***prior*** to your appointment, we have provided you with 3 ways for you to complete this information and return it to us.

- 1. If we have mailed this packet to you, we have enclosed a self-addressed stamped envelope for your convenience.*
- 2. If you are completing this patient packet online, please make sure you hit **send** after completing ALL sections. It is also suggested that you print out a copy for your records and bring to your appointment.*
- 3. If you are able to print out this packet from home, please fax or mail the requested documentation to the address / fax number listed below.*

Section III is a Bladder Diary. This, too, is very important for Dr. Miklos and Dr. Moore to make a complete diagnosis. We ask that you complete this and bring it with you to your appointment. The frequency volume chart should be for at least a ***72-hour period***, prior to your first appointment with the doctor. This is best done over the weekend when you do not have to have the everyday stresses' of work and/or activities. The amount of intake and amount voided do not have to be exact measurements and they can be listed either in cc's or ounces, using any type of measuring container. This information is very helpful to us regarding the management of your condition. We hope you will make every effort to complete this chart.

Section IV is important for you to keep for your reference. It contains information regarding women's health and our doctors, both Dr. John R. Miklos and Dr. Robert D. Moore.

We are looking forward to meeting you!!!!!!

Sincerely,

*John R. Miklos, MD
Robert D. Moore, DO*

3400 Old Milton Parkway Bldg. C ~ Suite 330, Alpharetta, GA 30005

Phone: 770-475-4499 Fax: 678-262-3671

www.miklosandmoore.com

www.lvratlanta.com

Atlanta Urogynecology Associates

Directions

Dr. Miklos and Dr. Moore's practice is located in Alpharetta, about 25 minutes from the Perimeter and 40 minutes from Buckhead.

From the South:

Take I-85 North, and take the exit for GA. Highway 400. Go through the tollbooth (\$.50) and continue on 400 North. Take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the North:

Take Highway 400 South, and take Old Milton Parkway (exit #10). Turn left onto Old Milton Parkway. Turn left at the fourth traffic light onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the East:

Take I-285 West, and take the exit for 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the West:

Take I-285 East, and take the exit for Ga. Hwy. 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.



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Traveling to Atlanta

Dr. Miklos and Dr. Moore are world-renowned surgeons and patients travel globally to Atlanta to seek their surgical expertise. Whether you are driving to Atlanta or traveling internationally, it is easy to make arrangements to have your surgery performed by Dr. Miklos and Dr. Moore. Our staff is dedicated to our patients and will assist you in your travel plans.

Hotel Locations located close to Northside Hospital

Hyatt Place Atlanta Perimeter

1005 Crestline Pkwy, Atlanta, GA 30328

770.730.9300

Our patients prefer the Hyatt Place Atlanta Perimeter as opposed to other hotels

- Close proximity to the hospital
- Free shuttle service
- Spacious rooms ~ open floorplan which includes a separate sitting area
- All rooms are equipped with a refrigerator and microwave

Other options close to Northside Hospital

Comfort Suites

6110 Dunwoody Rd, Atlanta, GA 30329

770.828.0330

The Westin Buckhead Atlanta

3391 Peachtree Rd, N.E., Atlanta, GA 30326

404.365.0065

Located near Atlanta Urogynecology Associates

Embassy Suites Alpharetta

5955 North Point Pkwy

Alpharetta, GA

678-566-8800

Hilton Garden Inn Atlanta Woodward

4025 Windward Plaza

Alpharetta, GA

770-360-7768

Hampton Inn North Point

10740 Westside Pkwy

Alpharetta, GA

770-640-5511

Staybridge Suites

3980 North Point Pkwy

Alpharetta, GA

770-569-7200

Atlanta Marriott Alpharetta

5750 Windward Pkwy

Alpharetta, GA

770-754-9600

Additional Services we can assist you with:

Transportation

Arrangements must be made for someone to take you home or to the hotel (if from out of town) from surgery. You will not be allowed to drive yourself or take any form of public transportation (cab, bus, etc.).

Nursing Care

If you are alone, you have the option to hire a nurse to come to the hospital, sign you out, transport you to the hotel, and make sure you are set up and comfortable for the night.

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Patient Registration Information

Patient Personal Information

Name: (Last, First, Middle Initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Social Security # _____

DOB: _____ Age: _____ Marital Status: Single Married Divorced Widowed

Spouses Name: _____ Spouse Social Security # _____

| Emergency Contact | Phone |
|--------------------------|--------------|
|--------------------------|--------------|

Patient Responsible Party Information

Responsible Party: _____ DOB: _____

Relationship to Patient: SELF SPOUSE OTHER _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Employer: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient Insurance Information

Name of Insured: _____ Relationship to Insured: _____

DOB: _____ Insurance Company: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____ City: _____

State: _____ Zip: _____

Secondary Insurance Company: _____ Relationship to Insured: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____ City: _____

State: _____ Zip: _____

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Atlanta Urogynecology Associates

Office Policies and Financial Payment Agreement

Atlanta Urogynecology Associates welcomes you. We thank you for selecting us for your healthcare needs. Drs. Miklos and Moore are leading surgeons in the field of urogynecology and all of our physicians take great pride in providing you with the highest quality of care. In order to provide you with the best service, we have the following Office Policies:

ARRIVAL TIME: Please arrive 15 minutes before your scheduled appointment time in order to complete the paperwork necessary for your visit. This will help us to keep to the scheduled appointment times. Updating paperwork is required for every visit to the office.

MISSED APPOINTMENTS: Missed office appointments are appointments cancelled or rescheduled with less than 48 hours notice. There is a charge of \$250 for missed appointments if you are a new patient and \$150 if you are a recurring patient. Atlanta Urogynecology reserves the right to reschedule patients that arrive more than 15 minutes late for their scheduled appointments. Repeated missed or cancelled appointments may result in termination of services.

RESCHEDULING: Because we are a surgical practice, emergency situations may arise that result in the physician being called away. As a result, your appointment may need to be rescheduled or the physician may run late. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign an Authorization to Release Medical Records form. There is a \$35 processing fee that will need to be paid in full before your request can be processed. Please allow two weeks for processing.

PATIENT FORMS: A critical component in our treatment plan is understanding your medical history and particulars about you and your current condition. Thus, it is necessary that you complete the Patient Medical History Questionnaire and other Questionnaires provided prior to your office visit. Failure to provide this information in advance may result in a Missed Appointment. If you need assistance completing the forms, you may choose to arrive 30 minutes before your scheduled appointment and someone will assist you.

FINANCIAL RESPONSIBILITY: Atlanta Urogynecology does not contract with insurance companies, therefore is typically considered an out of network provider and services are often reimbursed at a rate the insurer deems to be "reasonable and customary". Our relationship is with you. As a courtesy to you, we will attempt to obtain a pre-certification and file insurance claims for medically necessary procedures, but all charges (including consultation fees, deductibles, co-insurance, amounts charged in excess of reasonable and customary) are your responsibility. It is important that you read and understand YOUR insurance coverage and benefits and the requirements of your insurer. We expect patients or their guardian to be fully responsible for all charges regardless of insurance coverage. It is your responsibility to follow up with your insurer regarding the payment of your claim.

Please be advised we will not become involved in disputes between you and your insurance company, however, we will provide you with necessary, factual information regarding the services rendered, as necessary to assist you with your claim for benefits.

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In the event the insurance company sends the reimbursement check directly to you, it is your responsibility (since we have not asked for payment in full) to send us the check (endorsed over to Atlanta Urogynecology, PC), along with the Explanation of Benefits to our office.

FINANCIAL ESTIMATES: An estimate of proposed surgical procedures and corresponding fees will be provided to you in advance of scheduling your surgery. While every attempt is made to provide you with an accurate estimate, it is possible that additional and/or different procedures may be necessary. We also attempt to provide you with information about what the insurance company has indicated they will reimburse you for any medically necessary procedures, but what they actually pay is out of our control.

FINANCIAL PAYMENT: A **Surgical Deposit** of \$1,000 (in-state patients) or \$1,500 (out of state patients) is collected at the time surgery is scheduled. This is a *non-refundable* deposit, should you choose to cancel your surgery. Deductibles and estimated co-insurance amounts are collected at the time of the pre-operative office visit. The remainder of your bill is **due and payable within 60 days** (even if your insurance company has not paid their portion of your bill).

Deductibles and Co-Insurance (estimated) are due at the time services are rendered.

Patients without medical insurance will need to pay for services in full, at the time of service. (Payment methods accepted: Cash, Money Orders, Cashiers Checks, Visa, MasterCard, Amex, Discover) Please note: No personal checks over \$3500.

COLLECTIONS: I understand that in the event my account becomes past due (over 30 days) and all attempts to arrange payment have failed, my account may be placed for collection. I also understand that I will be responsible for all costs of collection including agency fees, court cost and/or attorney fees.

OUTSTANDING BILLS: There will be a 5% late fee for balances not paid when due unless other arrangements have been made.

RETURNED CHECK or CREDIT CARD CHARGE BACK FEE: \$35.00 for each check returned for insufficient funds or credit card charge back.

Should you have any questions regarding this form, please see a member of our front office staff for clarification prior to signing.

Date: _____

Signature of patient or guardian

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COMMON HEALTH INSURANCE COVERAGE TERMS

DEDUCTIBLE: *The deductible refers to the amount of money that the patient will need to pay before any payments are made from the insurance company. This is usually a yearly amount and will start over, the following year. Some office visit services may be available without meeting the deductible first. This is determined by your insurance company.*

CO-INSURANCE: *This is the amount that would be paid by the patient before the insurance pays. This is in addition to the deductible. Some insurance plans will allow the patient use some services with just the co-insurance payment. Like visiting the doctor, even before the deductible is met. This is determined by your insurance company.*

CO-PAYS: *This is another term used for, or in place of "co-insurance". Co-Pays are generally collected for office visit services as a flat dollar amount. Coinsurances are generally a percentage of the total amount due for services.*

LIFETIME MAXIMUM: *This is the maximum amount of money the health insurance policy will pay for the entire life. Pay attention to individual lifetime maximums and family lifetime maximums, as they can be different.*

EXCLUSIONS: *The exclusions (non-covered services} are the procedures and examinations that your policy does NOT cover. You will be responsible for these charges.*

PRE-EXISTING CONDITIONS: *This could be a disease or illness that the patient had prior to obtaining the insurance policy. Depending on your plan, preexisting conditions may not be covered at all, after a certain time frame, or will be covered. This is determined by your insurance company.*

WAITING PERIOD: *This is the time that the patient will have to wait until certain health services are payable by the insurance company. This time frame is determined by your insurance company.*

COORDINATION OF BENEFITS: *If the patient has two or more insurance carriers that will cover services, the insurance companies will NOT pay double benefits. In this case, the insurance companies will coordinate benefits to make sure each pays a portion of the service fees. This is determined by the insurance companies involved.*

GRACE PERIOD: *This is the amount of time one has to pay their health insurance premium after the original due date & before coverage is cancelled:*

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Insurance Policy

Fees for surgery are not finalized until the surgical procedure has been completed. While we plan certain procedures prior to surgery, one or more may or may not be necessary. Your pre-operative surgical deposit will be applied against the final total surgical fee.

After your surgery, a complete listing of procedures and charges will be submitted directly to your insurance company by this office, on your behalf. In the event that the insurance company reimbursement plus your pre-operative deposit is in excess of the total charges, the difference will be reimbursed directly to you.

Your post-operative visits will be billed directly to your insurance company. Excluding your annual deductible, we agree to accept a reasonable reimbursement in full for your post-operative care.

In the event that the insurance reimbursement is not received within 180 days of submission, you will receive a statement. A payment plan for the balance can be arranged, if needed.

Payment in full is the responsibility of the patient, regardless of the amount of insurance reimbursement.

We also will assist our patients in submitting appeals to their insurance carrier for additional payment, if you, the patient feels your insurance carrier should make additional payment for our services. However, during the appeals process, the patient will need to make regular payments to keep your account in “active” status. Should your insurance company make the additional payment, we will process to your account and if a refund is due, we will refund directly to you, the patient.

Patient Signature

Date

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Physician Payment Authorization

Patient Name: _____

Primary Insurance Policy Holder: _____

Primary Holder Date of Birth: _____

Insurance ID#: _____ Group #: _____

I hereby authorize my above named insurance provide to mail payment directly to said physician at Atlanta Urogynecology Associates, on my behalf. These payments should be made payable and mailed to:

**Urogynecology, PC
3400 Old Milton Parkway
Building C, Suite 330
Alpharetta, GA 30005**

Should my insurance company send payment directly to me, the patient, I will endorse and forward all payments to Atlanta Urogynecology Associates, for the services rendered. All checks will be forwarded to the address above.

I authorize Atlanta Urogynecology Associates to release any information pertinent to the resolution of claims and receiving payment to all my insurance carriers or attorney working on my behalf.

A photocopy of this assignment shall be considered as valid and effective as the original.

Signature

Date

Should you have ANY questions regarding the content of this form, please see a member of our front office staff for clarification, PRIOR TO SIGNING!!

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INSURANCE PAYMENT/FORWARD AGREEMENT
(BLUE CROSS/BLUE SHIELD ONLY)

Atlanta Urogynecology Associates is an Out-of-Network provider with patient's who have Blue Cross Blue Shield as their insurance carrier. Because of this, it is standard protocol for Blue Cross Blue Shield to send payments to the patient, for the services that are rendered by an Out-of-Network provider.

As the patient, and the insured by Blue Cross Blue Shield, it is your responsibility to forward all checks and associated paperwork (known as Explanation of Benefits) to our office. This information must be received in our office within 15 days of your receipt from Blue Cross Blue Shield. Failure to comply will result in our office charging your credit card for full amount of payment received by Blue Cross Blue Shield.

I _____, acknowledge the above statement and do understand that I am responsible for making sure all payments paid to me, for services rendered at Atlanta Urogynecology Associates is forwarded to them, upon receipt, or I will be charged in full for such payments, not sent immediately.

Patient Signature

Date

Card Type: (Check One) VISA AMEX MASTERCARD

Card Number: _____

Expiration Date: _____

Cardholder Name: _____

Billing Zip Code: _____

Authorizing Signature: _____

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Atlanta Urogynecology Associates

Medical History

Please complete the following information before your first visit

Name: _____, _____, _____
(Last) (First) (MI)

Date of Visit: ____/____/____
Date of Birth: ____/____/____

Chief Complaint (What problem(s) brings you to our office?)

Past Medical History: Please circle Y or N

| | | | |
|-----------------------------|---------------------------|------------------------|--------------------|
| Y / N Asthma | Y / N Pneumonia | Y / N Ulcers | Y / N Tuberculosis |
| Y / N Lung Disease | Y / N Depression/Anxiety | Y / N Kidney Infection | Y / N Lupus |
| Y / N Seizures / Convulsion | Y / N Venereal Disease | Y / N Kidney Stones | Y / N Arthritis |
| Y / N Heart Disease | Y / N High Blood Pressure | Y / N Arrhythmia | Y / N Migraines |
| Y / N Stroke | Y / N Fibromyalgia | | |

Y / N Cancer – If yes, what type? _____

Y / N Stomach Problems – type? _____

Y / N Glaucoma – type? _____

Y / N Thyroid Disease – type? _____

Y / N Diabetes – type? _____

Y / N Hepatitis – type? _____

Past Surgical History (List ALL surgeries with the date, if possible)

Previous incontinence / bladder surgeries: _____ NO _____ YES Type: _____

Other surgeries (Include any abdominal or plastic surgery)

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Atlanta Urogynecology Associates

Medical History – Page 2

Name: _____, _____
(Last) (First) (MI)

Allergies (Please list any allergies along with the type of reaction you experienced):

Medications (Please list all medications you currently take, including dosage and how often you take it. also include over-the-counter medications & herbal supplements):

Social History

Occupation: _____ Race: _____ Religion: _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widow _____ Separated

Spouse Name: _____ Spouse Occupation: _____

Regular Exercise: _____ Yes _____ No How Often? _____

Are you sexually active? _____ Yes _____ No How Often? _____
(This will help us choose the types of treatments more suitable for your lifestyle)

Cigarettes: Have you ever smoked Cigarettes? _____ Yes _____ No How many years? _____

Packs per day? _____ Are you currently smoking? _____ Yes _____ No

Caffeine: Coffee – cups per day _____ Caffeinated drinks (tea /soda) – cups per day _____

Alcohol: _____ Yes _____ No How often? _____ What is consumed? _____

Illegal Drugs: _____ Yes _____ No How often? _____ Which Drugs? _____

Family History (Check any conditions in your family & write in their relationship to you)

Condition

Relationship

_____ Heart Disease _____
_____ High Blood Pressure _____
_____ Stroke _____
_____ Breast Cancer _____
_____ GYN Cancer (Ovarian) _____
_____ Colon Cancer _____

GYN History

Last PAP Smear _____ Normal? _____
Last Mammogram _____ Normal? _____
Last GYN Exam _____ / _____ / _____
Last Menstrual Period _____ / _____ / _____
Problems with period? _____
Date of Menopause _____ / _____ / _____
of Pregnancies _____ # of Deliveries _____
of Vaginal Deliveries _____
of C-Sections _____

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Atlanta Urogynecology Associates

Medical History – Page 3

Name: _____, _____
(Last) (First) (MI)

Review of Symptoms (Check any conditions present today)

Constitutional

_____ Fever
_____ Chills
_____ Weight Loss

Gastrointestinal

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Blood in Stool
_____ Difficulty Swallowing

Psychiatric

_____ Depression
_____ Nervousness
_____ Anxiety
_____ Mood Swings

Respiratory

_____ Cough
_____ Shortness of Breath

Neurological

_____ Headache
_____ Blurred Vision
_____ Numbness
_____ Tingling
_____ Dizziness

Endocrine / Metabolic

_____ Hot Flashes
_____ Night Sweats
_____ Excessive Thirst
_____ Excessive Hunger
_____ Excessive Urine Output

Cardiovascular

_____ Heart Fluttering
_____ Chest Pain

Skin

_____ Bruise Easily
_____ Rash
_____ Change in Mole
_____ Non-healing Sore

Blood / Lymph

_____ Swollen Glands
_____ Bleeding Problems

Genital / Urinary

_____ Painful Urination
_____ Blood in Urine

_____ **I have none of these problems today**

Please fax, email or mail a completed copy of this paperwork to our office before your scheduled appointment.

DO NOT MAIL ORIGINALS

Keep the original paperwork and bring it with you to your appointment.

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Atlanta Urogynecology Associates - Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

(The last two columns on the right are for your doctor to assess your score. Please do not mark anything in these columns).

Patient's Name _____ Today's date: _____

| | 0 | 1 | 2 | 3 | 4 | SYMPTOM SCORE | BOTHER SCORE |
|--|-------|--------------|----------|--------|-----|---------------|--------------|
| 1 How many times do you go to the bathroom during the day? | 3-6 | 7-10 | 11-14 | 15-19 | 20+ | | |
| 2 a. How many times do you go to the bathroom at night? | 0 | 1 | 2 | 3 | 4+ | | |
| b. If you get up at night to go to the bathroom, does it bother you? | Never | Mildly | Moderate | Severe | | | |
| 3 Are you currently sexually active? Yes _____ No _____ | | | | | | | |
| 4 a. 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 | | | |
| b. If you have pain, does it make you avoid sexual intercourse? | Never | Occasionally | Usually | Always | | | |
| 5 Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)? | Never | Occasionally | Usually | Always | | | |
| 6 Do you have urgency after going to the bathroom? | Never | Occasionally | Usually | Always | | | |
| 7 a. If you have pain, is it usually... | | Mild | Moderate | Severe | | | |
| b. Does your pain bother you? | Never | Occasionally | Usually | Always | | | |
| 8 a. If you have urgency, is it usually.... | | Mild | Moderate | Severe | | | |
| b. Does your urgency bother you? | Never | Occasionally | Usually | Always | | | |
| SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) – SUBTOTAL | | | | | | | |
| BOTHER SCORE (2b, 4b, 7b, 8b) - SUBTOTAL | | | | | | | |
| TOTAL SCORE (Symptom Score + Bother Score) = | | | | | | | |

Atlanta Urogynecology Associates

PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

I have been made aware that Atlanta Urogynecology Associates has a Privacy Policy in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Atlanta Urogynecology Associates, I understand and acknowledge the following:

- 1. Atlanta Urogynecology has a privacy policy in effect in their offices.*
- 2. Atlanta Urogynecology has made this policy available to me for review, if requested.*
- 3. Atlanta Urogynecology has made me aware that I am entitled to a copy of this Privacy Policy.*

*This practice participates in research studies. Your chart may be reviewed by the staff at Atlanta Urogynecology Associates to gather data so that we can continue to provide our excellent quality of care. You will not **be** identified. Atlanta Urogynecology follows all HIPAA regulations.*

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Atlanta Urogynecology and have read and understand this acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ *NO, I do not want a copy, but acknowledge that the Privacy Policy exists.*

_____ *YES, I do want a copy of the Privacy Policy.*

Patient Name

Patient Signature

Date

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QUALITY OF LIFE QUESTIONNAIRE

Name: _____

Date of Exam: ____/____/____

Has urine leakage and or prolapse affected your:

None

Slightly

Moderately

Greatly

Ability to do household chores?

Physical recreation such as walking, swimming
or exercise?

Entertainment activities (movies, concerts, etc)?

Ability to travel by car or bus more than 30 minutes?

Participate in social activities outside the home?

Emotional health (nervousness, depression, etc)?

Feeling frustrated?

**Do you experience, and, if so how much are you
bothered by:**

Frequent urination?

Urine leakage related to feeling of urgency?

Urine leakage related to physical activity, coughing,
or sneezing?

Small amounts of urine leakage (drops)?

Difficulty in emptying your bladder?

Pain or discomfort in the lower abdomen or
Genital area?

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

I hereby authorize Atlanta Urogynecology Associates to release information to any medical facility or physician to which I may be referred by this office. I authorize Atlanta Urogynecology Associates to obtain copies of medical information from any medical facility or physician, which may be related to my care and or treatment. I also authorize Atlanta Urogynecology Associates to release medical records from this office, related to my medical history, physical examination, or surgery to other physicians who care for me to provide continuity of care and communication between my physicians on my behalf.

I hereby release this office and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may arise as a result of the release of information authorized by this Consent Form.

I have read and understand this Consent for Release of Medical information and have voluntarily and knowingly signed such consent.

Patient Signature

Date

Parent/Guardian Signature

LIST OF PHYSICIANS WHO CARE FOR YOU:

| | | |
|---------------|--------------------|---------------------------------|
| _____ Name | _____ Specialty | _____ Address & Phone Number |
| _____ Name | _____ Specialty | _____ Address & Phone Number |
| _____ Name | _____ Specialty | _____ Address & Phone Number |
| _____ Name | _____ Specialty | _____ Address & Phone Number |

3400 Old Milton Parkway Bldg. C ~ Suite 330, Alpharetta, GA 30005

Phone: 770-475-4499

Fax: 678-262-3671

www.miklosandmoore.com

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Atlanta Urogynecology Associates

AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____ - _____ - _____

Date of Birth: _____

Name & Address of Physician Sending Records:

The above named physician(s) are hereby authorized to release to:

John R. Miklos, MD

Robert D. Moore, DO

Gretchen K. Mitchell, MD

I, _____, hereby authorize the above named facility/physician to release my medical records, including any psychiatric, alcohol or drug abuse information. Specifically, the following:

- | | |
|---|---|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Psychiatric Notes |
| <input type="checkbox"/> History / Physical | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Special Diagnostic Reports (EKG, EEG, etc) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |

The information is needed for the following purpose (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Continued care by the receiving facility/physician | <input type="checkbox"/> Legal proceedings or advise |
| <input type="checkbox"/> Claims settlement with insurance company | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Needed to receive aid by the above named agency | <input type="checkbox"/> Other: _____ |

SIGNATURE: (This authorization is valid for a period of 90 days from the date signed)
I have read and understand this Consent for Release of Medical Information, and have voluntarily and knowingly signed such consent.

Signature

Date

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SPECIAL NOTE:

If you will be menstruating at the time of your visit, this does not affect your exam in any way. However, please remove your tampon prior to your exam.

Thank you

Bladder Diary

Patient Name: _____

Date: _____

Keep track of your urine output for 72 hours prior to your appointment.

*Please measure the amount in ounces or cc's. These markings can be found on a measuring cup. **This record is VERY IMPORTANT** in deciding the treatment for your bladder problems.*

Special Note

If you wear a pessary, please remove it three (3) days PRIOR to your appointment.

Please feel free to contact our office with any questions.

Thank You

Atlanta Urogynecology Associates

Voiding Diary – Day 1

Patient Name: _____

Date: _____

| Time of Day | Amount Voided (ounces or cc) | Amount of fluid taken in (drinks) oz or cc | Type of fluid consumed (water, tea, beer, etc) | Urgency or pain before voiding? Yes or No | Leakage of urine any time prior to voiding? Yes or No |
|-------------------------|------------------------------|--|--|---|---|
| 7 AM | | | | | |
| 8 AM | | | | | |
| 9 AM | | | | | |
| 10 AM | | | | | |
| 11 AM | | | | | |
| 12 NOON | | | | | |
| 1 PM | | | | | |
| 2 PM | | | | | |
| 3 PM | | | | | |
| 4 PM | | | | | |
| 5 PM | | | | | |
| 6 PM | | | | | |
| 7 PM | | | | | |
| 8 PM | | | | | |
| 9 PM | | | | | |
| 10 PM | | | | | |
| 11 PM | | | | | |
| 12 AM | | | | | |
| 1 AM | | | | | |
| 2 AM | | | | | |
| 3 AM | | | | | |
| 4 AM | | | | | |
| 5 AM | | | | | |
| 6 AM | | | | | |
| Total for 24 HRS | | | | | |

Comments: _____

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Voiding Diary – Day 2

Patient Name: _____

Date: _____

| Time of Day | Amount Voided (ounces or cc) | Amount of fluid taken in (drinks) oz or cc | Type of fluid consumed (water, tea, beer, etc) | Urgency or pain before voiding? Yes or No | Leakage of urine any time prior to voiding? Yes or No |
|-------------------------|-------------------------------------|---|---|--|--|
| <i>7 AM</i> | | | | | |
| <i>8 AM</i> | | | | | |
| <i>9 AM</i> | | | | | |
| <i>10 AM</i> | | | | | |
| <i>11 AM</i> | | | | | |
| <i>12 NOON</i> | | | | | |
| <i>1 PM</i> | | | | | |
| <i>2 PM</i> | | | | | |
| <i>3 PM</i> | | | | | |
| <i>4 PM</i> | | | | | |
| <i>5 PM</i> | | | | | |
| <i>6 PM</i> | | | | | |
| <i>7 PM</i> | | | | | |
| <i>8 PM</i> | | | | | |
| <i>9 PM</i> | | | | | |
| <i>10 PM</i> | | | | | |
| <i>11 PM</i> | | | | | |
| <i>12 AM</i> | | | | | |
| <i>1 AM</i> | | | | | |
| <i>2 AM</i> | | | | | |
| <i>3 AM</i> | | | | | |
| <i>4 AM</i> | | | | | |
| <i>5 AM</i> | | | | | |
| <i>6 AM</i> | | | | | |
| Total for 24 HRS | | | | | |

Comments: _____

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Voiding Diary – Day 3

Patient Name: _____

Date: _____

| Time of Day | Amount Voided (ounces or cc) | Amount of fluid taken in (drinks) oz or cc | Type of fluid consumed (water, tea, beer, etc) | Urgency or pain before voiding? Yes or No | Leakage of urine any time prior to voiding? Yes or No |
|--------------------------------|-------------------------------------|---|---|--|--|
| <i>7 AM</i> | | | | | |
| <i>8 AM</i> | | | | | |
| <i>9 AM</i> | | | | | |
| <i>10 AM</i> | | | | | |
| <i>11 AM</i> | | | | | |
| <i>12 NOON</i> | | | | | |
| <i>1 PM</i> | | | | | |
| <i>2 PM</i> | | | | | |
| <i>3 PM</i> | | | | | |
| <i>4 PM</i> | | | | | |
| <i>5 PM</i> | | | | | |
| <i>6 PM</i> | | | | | |
| <i>7 PM</i> | | | | | |
| <i>8 PM</i> | | | | | |
| <i>9 PM</i> | | | | | |
| <i>10 PM</i> | | | | | |
| <i>11 PM</i> | | | | | |
| <i>12 AM</i> | | | | | |
| <i>1 AM</i> | | | | | |
| <i>2 AM</i> | | | | | |
| <i>3 AM</i> | | | | | |
| <i>4 AM</i> | | | | | |
| <i>5 AM</i> | | | | | |
| <i>6 AM</i> | | | | | |
| <i>Total for 24 HRS</i> | | | | | |

Comments: _____

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