Emad Hashemi, M.D.
Women's Center For Urogynecology

520 Superior Ave., Suite 200
Newport Beach, CA 92663
Tel: (949) 706-2500 **Fax:** (949) 999-0262

NEW PATIENT PACKET

Thank you for choosing Women's center for Urogynecology.
Our office and staff look forward to serving you.

Prior to your appointment:

- Please complete the attached New Patient Paperwork. Be sure to read the Financial Policy and the Notice of Privacy Practices before signing the consent forms.
- If for any reason yu are unable to keep your appointment, please all our office to reschedule your visit to suit your needs.

The day of your appointment:

- There may be additional paperwork for you to fill our once you arrive, so please be sure to arrive early to your scheduled appointment to complete the registration process.
- Bring a current photo ID, (such as a drivers license) and your insurance cards. If you do not have your insurance card, please bring a legible copy. If you do not have a copy of your card, please contact your insurance carrier before your visit and bring proof of eligibility with you.
- Be prepared to pay and co-payment or un-met deductible required by your insurance at your visit.

Please feel free to call our office at (949) 706-2500 between 9:00 am and 5:00 pm, Monday through Friday, with any questions or concerns regarding this paperwork.

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REGISTRATION FORM

DATE REGISTERED | MEDICAL RECORD NUMBER | ( ) NEW | ( ) RE-VISIT

PATIENT INFORMATION

LAST NAME | FIRST NAME | SOCIAl SECURITY NO. | DATE OF BIRTH | SEX ( )F ( )M

STREET ADDRESS | APT. # | MARITAL STATUS: S | M | W | SEP | D | PARENTS FIRST NAMES: MOTHER | FATHER

E-MAIL:

CITY/STATE | ZIP CODE | Home Phone: | Cell Phone:

EMPLOYER INFORMATION

EMPLOYER NAME | PATIENT'S OCCUPATION

EMPLOYER'S STREET ADDRESS | CITY/STATE | ZIP CODE | TELEPHONE NO.

FINANCIALLY RESPONSIBLE PERSON (If not Patient)

NAME | RELATIONSHIP

ST]REET ADDRESS | CITY/STATE | ZIP CODE | TELEPHONE NO.

FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER INFORMATION

EMPLOYER | EMPLOYER STREET ADDRESS

CITY/STATE | ZIP CODE

EMERGENCY PERSON INFORMATION

NAME | HOME TELEPHONE NO.

RELATIONSHIP | BUSINESS TELEPHONE NO.

PRIMARY CARE DOCTOR

NAME | TELEPHONE NO.

ADDRESS

REFERRING DOCTOR

NAME | TELEPHONE NO.

ADDRESS

INSURANCE

1	INSURANCE CARRIER NAME	ID NUMBER	GROUP #	SUBCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS	CITY	STATE	ZIP CODE	SUBSCRIBER SS#:
2	INSURANCE CARRIER NAME	ID NUMBER	GROUP#	SUBCRIBER NAME	DATE OF BIRTH
	INSURANCE CARRIER ADDRESS	CITY	STATE	ZIP CODE	SUBSCRIBER SS#:

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PATIENT QUESTIONNAIRE

NAME: ______________________ **DATE:** ____________

How did you find out about our office? ______________________

Reason for visit: ______________________

GYNECOLOGIC HISTORY: Please respond to all questions.

First Day of Last Menses ____________
# of Days Between Periods ____________
How Long is Flow? ____________
Is Flow Heavy Medium Light
(circle one)
Cramps? ____________
Cramp Medication? ____________

Date of Last Pap Smear/Exam ____________
Any Abnormal Pap Smears? ____________
Surgery to Cervix? ____________

Date of Last Mammogram ____________
Breast Lumps/Cysts ____________
Do You Do Self Breast Exams? ____________
Did You Mother Take DES When Pregnant With You? ____________

Infections: (now or in the past)
- ❒ Gonorrhea
- ❒ Chlamydia
- ❒ HIV/AIDS
- ❒ Warts/HPV
- ❒ Herpes
- ❒ Syphilis
- ❒ Trichomonas
- ❒ Recurrent Yeast Infection

Do You Use Any of the Following Contraceptives?
- ❒ Condoms
- ❒ Diaphragm
- ❒ Cervical Cap
- ❒ Birth Control Pills
- ❒ Natural Family Planning
- ❒ Vasectomy of Partner
- ❒ Tubal Ligation
- ❒ Norplant
- ❒ Depo Provera
- ❒ IUD

Do You Have a Sexual Partner? ❒ Yes ❒ No
❒ Male ❒ Female

OBSTETRICAL HISTORY

Number of Pregnancies (Including miscarriages and/or abortions): ____________

Delivery Date	Gest. Weeks	Type of Delivery	Sex	Birth Weight	Complications

MEDICAL HISTORY
(Please Check "Yes" or "No")

Neurologic
- Seizures ❒Yes ❒ No
- Muscle Weakness ❒Yes ❒ No
- Migraines ❒Yes ❒ No

Ear/Nose/Throat/Eyes
- Dentures ❒Yes ❒ No
- Cataracts ❒Yes ❒ No

Hepatitis ❒Yes ❒ No

Diabetes ❒Yes ❒ No

Thyroid Disorder ❒Yes ❒ No

Mental Health Disorder
- Depression ❒Yes ❒ No
- Bipolar ❒Yes ❒ No
- Anxiety Disorder ❒Yes ❒ No

Vaccinations Up-to-Date ❒Yes ❒ No

Have You Had Blood Transfusion ❒Yes ❒ No

Heart Disease
- Mitral Valve Prolapse ❒Yes ❒ No
- Angina ❒ Yes ❒ No
- High Blood Pressure ❒ Yes ❒ No

Lung Disorder
- Asthma ❒ Yes ❒ No
- Emphysema ❒ Yes ❒ No

Bladder Problems
- Urine Leakage ❒Yes ❒ No
- Recurrent Infections ❒ Yes ❒ No

Physical Impairment
- Mobility ❒ Yes ❒ No
- Deafness ❒Yes ❒ No
- Blindness ❒ Yes ❒ No

Do You Feel Safe At Home ❒Yes ❒ No

Have You Had:
- Chicken Pox ❒Yes ❒ No
- Measles ❒Yes ❒ No

SURGICAL HISTORY:

List type of surgery, When, Where, and Anesthesia

____
____
____

List Medication, Dosage and Frequency

____
____
____

List ALLERGIES:

Are You on Blood Thinner Medication Y/N

____
____

Family History – List Relationship:

Breast Cancer or Female Cancers: ____________________
Diabetes: ____________________
Asthma/Lung Disease: ____________________
Cancer: ____________________
Other: ____________________

Heart Disease: ____________________
High Blood Pressure: ____________________
Tuberculosis: ____________________
Seizures: ____________________

Your Occupation: ____

Have You Ever Used: (Please Check)

❒ Cigarettes / Tobacco
❒ Heroin
❒ Alcohol
❒ Marijuana
❒ Speed
❒ Valium
❒ Cocaine./Crack
❒ Other ____________________

Patient Signature: ______________________________ Date: ____________________

Physician Signature: ____________________ Date: ____________________

URINARY STRESS INCONTINENCE QUESTIONNAIRE

1. Do you leak urine when you cough, sneeze, laugh or exercise?	Yes	No
2. Do you ever have such a strong need to urinate that if you do not reach the toilet, you will leak?	Yes	No
3. If your answer to #2 is "yes", do you ever leak before you reach the toilet?	Yes	No
4. How many times during the day do you urinate?	______	
5. How many times do you urinate after going to bed at night?	______	
6. Do you wet the bed?	Yes	No
7. Do you develop an urgent need to urinate when you are nervous, under stress or in a hurry?	Yes	No
8. Do you ever leak during or after sexual intercourse?	Yes	No
9. How often do you leak urine?	______	
10. Do you wear a pad because you are leaking?	Yes	No
11. Have you had bladder or kidney infections?	Yes	No
12. Do you have pain or discomfort when you urinate?	Yes	No
13. Do you now or have you ever had blood in your urine?	Yes	No
14. Do you find it hard to start urinating?	Yes	No
15. Does it take you a long time to empty your bladder (slow urinary stream)?	Yes	No
16. Do you strain to pass your urine?	Yes	No
17. After urinating, do you have dribbling or feel that your bladder is still full?	Yes	No
18. Have you had any prior surgeries for this condition?	Yes	No

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I ______________________________________ hereby authorize **Dr. Emad Hashemi** of Women's Center For Urogynecology to obtain the following medical information from : ____.

Address:

Either mail or fax the following information to the above address or fax number:

Recent Lab Results ___________________

Medical History ______________________

Surgeries ___________________________

Treatments __________________________

Other ____

____
Patient or Patient Representatives Signature

Date: _______________________________

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated for personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill attorney for charges incurred due to your personal injury case.

Co-signature: If this or another Financial Policy is signed by a person, other than the patient, that person is responsible until canceled in writing. If written cancellation is received, and accepted by us in writing it becomes effective with any subsequent charges.

Effective Date: Once you have signed the attached agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Transferring records: You will need to request in writing, and pre pay co paying charge of (25c) twenty five cents per page if you want to have your records sent to another doctor. You are authorizing us to include all relevant information, including your payment history. If you are requesting your record to be transferred from another doctor or organization to us, you authorized us to receive all relevant information, including your payment history.

Woman's Center for Urogynecology

Emad Hashemi M.D.
FPMRS, FACOG

Financial Policy

520 Superior Ave., Suite 200
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Phone: (949) 706-2500
Fax: (949) 999-0262

Patient:______________________________

This is an agreement between **Dr. Emad Hashemi M.D., Woman's Center for Urogynecology** Creditor, and the patient/debtor named on this form.

In this agreement the words "you," 'yours" means the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payment credited. The words "we," "us," refers to **Dr. Emad Hashemi M.D., Woman's Center for Urogynecology.**

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payment and credit applied to your account during the month.

Payment options if you have no insurance:

A. You may choose to pay by cash, checks or credit card on the day the treatment is rendered. We accept MasterCard Visa, American Express, Discover, Debit, Checks & Money Order.

Payment Options if you have insurance:

A. Will bill your insurance company first then balance bill you if necessary. However, you must pay your co-pay at the time of your visit.
B. You can choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, checks, or credit card.
C. If you choose to pay for all your treatment, we will request your insurance carrier to send their payment directly to you.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when statement is issued, and is past due if not paid within (30) days.

Charges to account: We have the right to cancel your privilege to make payment by credit card at any time. If we elect to do so, further visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to such contract. We will bill your insurance company as courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and the amount it pays. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and /or preauthorization, you are responsible for obtaining it. Failure to obtain the referral or/preauthorization may result in a lower payment from the insurance company.

Required payment: Any co-pay required by your insurance company must be paid at the time of service. This is an insurance requirement.

Return checks: There is a $25 fee for any checks returned by your bank.

Missed appointment fee: Patients, who do not show up for an appointment, will be charged $25 for established patient and $50 for new patients. This must be paid before a new appointment is scheduled. Patients with three (3) missed appointments will be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection cost which is incurred. If we have to refer collections to an attorney, you agree to pay all attorneys' fees, which we incur, plus all court costs.

Waiver of confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

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OFFICE NOTICE OF PRIVACY PRACTICES
Effective as of January 1, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CARFULLY.

This Office uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of this Office.

How This Office May Use or Disclose Your Health Information

Treatment: We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, that is related to your treatment, may be necessary for us to determine what treatment you should receive. We will also record actions taken by them in the course of your treatment and note how you respond to treatment.

Payment: We may use and disclose your health information to others in order to receive payment for treatment and services you receive. For example, a bill may be sent to you or a third-party, such as insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in treatment.

Health Care Operations: We may use and disclose health information about you for operations purposes. For example, your health information may be used to evaluate performance of our staff; assess quality of care in your case and similar cases; learn how to continually improve quality and effectiveness of healthcare we provide.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest.

Required by Law: We may use and disclose information about you as required by law, such as for judicial and administrative proceedings, or to report information related to victims of abuse, neglect or domestic violence, or assist law enforcement officials in their law enforcement duties.

Public Health: Your information may be used or disclosed for public health activities, such as assisting authorities to prevent or control disease or injury, or other health oversight activities.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Information may be disclosed for organ or tissue donation purposes.

Research: Your information may be used for approved research purposes subject to established protocols to ensure the privacy of your health information.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be disclosed for certain government functions such as protection public officials or reporting to branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses: Other uses and disclosures will be made only with your written authorization and you may revoke authorization except to the extent the Office has taken action in reliance on such.

Your Health Information Rights

- To inspect and obtain a copy of your health record.
- To request that your health record be amended.
- To request communications of health information by other means or to other locations.
- To receive an accounting of disclosures made by this Office of your health information.
- To request restriction on certain uses/disclosures of information, subject to our approval.

Obligations of this Office

- To maintain privacy of your health information;
- To provide you with this notice of our policies concerning your health information.
- To abide by the terms of this notice;
- To notify you if we do not agree to your request to restrict disclosure of your information.
- To accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

We reserve the right to change our information practices and make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you.

Contact and/or Complaint information

You may complain to us or to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

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ACKNOWLEDGEMENT OF REVIEW OF OFFICE PRIVACY

By signing this document, I acknowledge that I have received a copy of the Office's Privacy Practices Policies.

Patient's Name: ______________________________

Responsible Party
(If not the patient):______________________________

Signature:______________________________ **Date:** ____________

AUTHORIZATION TO RECEIVE RESULTS BY EMAIL **YES** ☐ **NO** ☐

E-Mail Address: ______________________________

Signature: ______________________________

Office Use Only

Date acknowledgement received:____________________

- **OR –**

Reason acknowledgement was not obtained:

____
____
____
____

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ACKNOWLEDGEMENT OF REVIEW &
RECEIPT OF OFFICE FINANCIAL POLICY

By signing this document, I acknowledge that I have received and reviewed a copy of the Office Financial Policy and agree to abide by the tenants outlined in said document.

Patient's Name: ____

Responsible Party
(If not the patient):____

Signature:_________________________________**Date:** ___________

....

Office Use Only

Date acknowledgement received:_________________

Witnessed by:____________________________________

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Patient Rights and Responsibilities:

As a patient you have the right to:

- Take part in your health care and treatment
- Know the names of the people caring for you
- Be treated with respect and dignity in a safe and private sitting
- Be informed about your illness and treatment, including options for your care
- The right to have your treatment and other information kept private. Only by law may record be released without patient permission
- Get another opinion about your illness or treatment
- Privacy of your health care records
- Talk with the clinic manager about any questions or problems with your care
- Respect for your cultural, social, spiritual, and personal values and beliefs
- Know about legal reporting requirements
- Ask for special arrangements if you have a disability
- Refuse treatment, care and services as allowed by law
- Know the cost of your care and ways you may pay for your care

As a patient you the responsibility to:

- Tell your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both care givers and other patients
- Cancel or reschedule appointments so that another person may have that time slot
- Pay your bills on time
- Use medications or medical devices for yourself only
- Inform the medical provider if you become worse or have an unexpected reaction to a medication
- Give written permission to release your other health records to our office when necessary
- Let your provider know about your insurance coverage, and any change to it
- Let your provider know when the treatment plan no longer works for you
- Tell your provider about medication changes, including medication given to you by others
- Give your provider the information they need, in order to provide the best possible care

If you have any questions, please tell your medical provider or the office manager.