Bay Area Gynecology Oncology

Patient Consent/Agreement Form

NAME: _____ DOB: _____

CONSENT FOR TREATMENT
I hereby consent to examination and the performance of all treatments that may be considered medically necessary or advisable. This may include the administration of needed anesthetics, the use of prescribed medication, the use of diagnostic procedures and the use of x-rays and laboratory test.

RELEASE OF INFORMATION
I authorize the release of any medical information to and from any medical facilities, physicians, and/or my insurance company.

I also authorize the following person(s) to receive any of my medical information:

_____

PRIVACY POLICY ACKNOWLEDGEMENT
I acknowledge that I have been given ***The Notice of Privacy Practices*** for Bay Area Gynecology Oncology.

PAYMENT: I understand that I am responsible for payment for services **including co-payments**, balances and charges for services not covered by insurance. All payments are due at the time of service. I authorize the payment of insurance benefits to one of the following, James Lilja, M.D., Jeff F Lin, M.D., or Bay Area Gynecology Oncology. I understand that **late** payments may incur a charge of 5% interest, per day, until paid.

REFERRAL/AUTHORIZATIONS: I agree to provide a referral or an authorization from my PCP-Primary Care Physician or referring physician if my insurance is an HMO at the time of my visit. If no referral form is provided, my visit may be re-scheduled.

MEDICAL RECORD COPIES/DISABILITY FORM CHARGES: Disability form completion and copying of medical records incur a $50.00 charge and will not be completed without payment.

CHANGE OF ADDRESS AND/OR INSURANCE:
I agree to notify Dr. Lilja's office of any changes to my address, phone number, employment, and, insurance. I have read all the above information on this sheet and have agreed that (regardless of my insurance) I will pay for all Medical Services provided by James Lilja MD or any health care professional acting on their behalf. **As a courtesy**, our billing service will assist you in filling your insurance claim, within reasonable bounds. This office will expect prompt payment from your insurance company (usually within 30 days of the billing date). If this is not the case, we ask that you help us collect from your Insurance Carrier or settle your bill at the end of this time period.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the release of any **Medical Information** necessary to process these claims, and I request payment of insurance benefits to: James Lilja, M.D., Katherine Volpe, M.D. and/or Bay Area Gynecology Oncology. I agree that unpaid insurance balances are my full responsibility. I also authorize the release of any information acquired in the course of my examination or treatment to hospital, other physicians, and/or my insurance company. Ultimately I am responsible for the balance of my account for any services and/or charges rendered.

LATE/NO SHOW FEES: I agree to appear **within 15 min of my appointment time**. I agree to notify the office if I must cancel an appointment **greater than 24 hours prior to my appointment**. If I fail to do so, I agree to pay the Charges for a 15 min office evaluation (indexed to the current year).

TRANSLATION: I authorize the following person(s) to provide translation services:_____

RX HUB INQUIRY: I hereby provide consent for the Practice of Bay Area Gynecology Oncology, to obtain my Rx history using the SureScripts-Rx Hub Network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx has certified Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system to system communications.

AUTHORIZATION FOR HEALTH CARE MARKETING COMMUNICATIONS:

Bay Area Gynecology Oncology (BAGO) values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. Certain types of promotional communications cannot be sent to you unless you provide written authorization to receive them. BAGO will limit these to no more than four per year. You have a choice whether to receive these communications. Please check one box below and add your initials to indicate whether you authorize promotional communications.

[ ] I authorize_____ [ ] I do not authorize_____

AUTHORIZATION FOR INTEROPERABILITY

_____ _____

Patient / Guardian Signature Date

Bay Area Gynecology Oncology
455 OConnor Drive Ste 370 San Jose, CA 95128
P# 408-827-4274 F#408-827-4275

Patient Registration Form

Circle One

Patient Name: _____ **Date of Birth:** _____ FEMALE MALE

ADDRESS: _____ **CITY** _____ **ST**_____ **ZIP**_____

Home Phone: (_____)_____ **Cell**: (_____)_____ **Work Phone**: (_____)_____

SSN:_____-_____-_____ **EMAIL**: _____

Circle if okay to leave messages at: **HOME** **WORK** **CELL** **Marital Status** (circle): S M W D

EMPLOYER: _____PHONE: (_____) _____

Race:_____ Ethnicity:_____ Primary Language: _____

** **EMERGENCY CONTACT**:**

Name: _____ PHONE: (_____) _____Relation: _____

Address, City State Zip: _____

Pharmacy Name & Location:_____**Pharmacy Phone:** _____

General Practitioner Internist: _____ Gynecologist: _____

Cardiologist: _____ Other Specialist:_____

Referring Physician: _____ Phone: _____

Reason for visit today:_____

THE FOLLOWING MUST BE COMPLETED ALONG WITH BRINGING IN YOUR INSURANCE CARD

PRIMARY INSURANCE CARRIER:_____

ID #: _____ MEDICAL GROUP: _____

INSURES'S NAME: _____INSURED'S **DOB**: _____

SECONDARY INSURANCE CARRIER:_____

ID #: _____ MEDICAL GROUP: _____

INSURES'S NAME: _____INSURED'S **DOB**: _____

SIGNED: _____ **DATE**: _____

For Office use ONLY:

Height: _____ Weight: _____ B/P: _____ Temp: _____ P: _____

Initials _____ Date of Birth _____

Urogynecology New Patient Intake

Your Name: _____ Today's Date: _____

Your Age: _____

Name of the doctor who sent you to see us: _____

Main reason for your visit:_____

Please answer the following questions:

1. How long has this been going on? □ Less than 6 months □ 6 months – 1 year □ 1 -2 years
2. Since your problem started is it ….. □ Getting better □ Staying the same □ Getting worse
3. How often do you experience urinary leakage? (Please check one)
   - ___ Never, I do not leak urine
   - ___ Less than once a month
   - ___ A few times a month
   - ___ A few times a week
   - ___ Every day and/or night
4. How much urine do you lose each time? (Please check one)
   - ___ None, I do not leak urine
   - ___ Drops
   - ___ Small Splashes
   - ___ More
5. Do you leak urine when you leaking with cough/sneeze/laugh/exercise: □ Yes □ No
6. Do you ever leak urine because you can't make it to the bathroom on time? □ Yes □ No
7. Do you have to wear pads to protect against urine leakage? □ Yes □ No
8. Do you ever wet the bed? □ Yes □ No
9. Number of times you wake up at night to urinate (please circle): 1 2 3 4 5
10. Have you ever been on medication for your bladder problems? □ Yes □ No
11. What bladder medications did you take and for how long? _____
12. Is your urine stream: □ continuous □ strong □ variable □ weak
13. Do you feel like you can completely empty your bladder? □ Yes □ No
14. Have you had many urinary/bladder infections? □ Yes □ No
    - If yes, how many in the past year? _____
    - What medications have you taken for these infections? _____
15. Do you notice anything falling or protruding out of the vagina? □ Yes □ No
16. If you have prolapse, do you push it back in to urinate or move your bowels? □ Yes □ No □ n/a
17. How are your bowel movements? □ normal □ constipated □ diarrhea □ variable
18. Do you ever leak stool? □ Yes □ No
19. Are you sexually active? □ Yes □ No
    - If yes, please complete the PISQ-12 questionnaire
20. Do you have vaginal dryness? □ Yes □ No
21. Do you have any pain with intercourse? □ Yes □ No
22. Are you: □ not in a relationship at present □ have a partner □ married □ widowed
23. Would you like to discuss sexual issues today? □ Yes □ No

Have you had any of the following conditions in the past 6 months – either daily or sporadically?

Constitutional
- ☐ Fever or Chills
- ☐ Unintended weight loss

Cardiovascular
- ☐ Chest pain
- ☐ Heart Palpitations

Respiratory
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic or frequent cough

Endocrine
- ☐ Diabetes
- ☐ Hot flushes
- ☐ Excessive eating

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Difficulty swallowing
- ☐ Heartburn

Genitourinary
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Kidney or bladder stones

Blood/Lymph
- ☐ Swollen glands
- ☐ Bleeding problems

Skin
- ☐ Rash/Hives
- ☐ Changes in moles
- ☐ Non-healing sores on skin or in mouth

Psychiatric
- ☐ Depression
- ☐ Nervousness
- ☐ Difficulty sleeping

Neurological
- ☐ Frequent or severe headaches
- ☐ Muscle weakness
- ☐ Blurry vision
- ☐ Tingling/ numbness
- ☐ Dizziness
- ☐ Fainting (loss of consciousness)

Please list your medical history / problems:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all the surgeries you've had and date (please include cesarean sections and plastic surgery)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GYN and Pregnancy History:

Number of vaginal deliveries: _____ Were forceps used? _____ Any tear into the rectum? _____
Number of C-Sections: _____ Weight of your largest baby _____
Do you still get periods? ☐ Yes ☐ No
If you still have periods, what is the date of your last period? _____
If you stopped having periods, how old were you when you had your last period? _____
Is there any chance you could be pregnant? ☐ Yes ☐ No
Do you ever have irregular bleeding or spotting from the vagina? ☐ Yes ☐ No

Any difficulty getting pregnant ? IVF _____
Date of last pap smear: _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal pap smear? ☐ Yes please explain: _____ ☐ No

List all medications that you take and the dose:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you **allergic** to any medications? Y N

Are you allergic to Latex Y N

If yes, please list allergies and what happens:

_____
_____
_____
_____
_____
_____
_____
_____

Health Maintenance/Screening:

Date of your last mammogram: _____ Was it normal? Y N

Date of your last colonoscopy: _____ Was it normal? Y N

Social History:

Who do you live with? _____

Do you work outside of your home?	Y N	If yes, please list profession:	_____
Do you smoke cigarettes?	Y N	If yes, how many per day?	_____
Do you drink alcohol?	Y N	If yes, how much per day/week?	_____
Any other recreational substances	Y N	If yes, please list:	_____
Do you exercise on a regular basis?	Y N	If yes, how often per week?	_____

Family History: Does anyone in *your family* have any of the following conditions?

Uterine Cancer Y N	Colon Cancer	Y N	Blood Clots	Y N
Ovarian Cancer Y N	Breast Cancer	Y N		
Cervical Cancer Y N				
Bladder Cancer Y N	other_____			

Patient Signature:_____ **Date:_____**