Women's Center for Pelvic Wellness

David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

PATIENT DEMOGRAPHICS

_____ , _____ __. ___ /___ / _____ _____

LAST NAME FIRSTNAME M.I DATE OF BIRTH (MM/DD/YYYY) AGE

_____ _____ _____ _____ _____

ADDRESS: ST. NAME & NUMBER APT./HOUSE # CITY STATE ZIP

___ ___ ___ ___ S M W D _____

(LAST 4 DIGITS) SOCIAL SECURITY NUMBER MARITAL STATUS EMAIL ADDRESS

(_____) _____ (_____) _____ (_____) _____

EMERGENCY: NAME / CONTACT # WORK PHONE CELL PHONE

_____- _____ - _____

REFERRING PHYSICIAN ADDRESS PHONE NUMBER

_____- _____ - _____

PRIMARY CARE PHYSICIAN ADDRESS PHONE NUMBER

_____- _____- _____

GYNECOLOGIST ADDRESS PHONE NUMBER

_____- _____ - _____

PHARMACY ADDRESS PHONE NUMBER

_____ _____ _____

PRIMARY INSURANCE SUBSCRIBER'S NAME SUBSCRIBER'S DATE OF BIRTH

_____ _____ _____

SECONDARY INSURANCE SUBSCRIBER'S NAME SUBSCRIBER'S DATE OF BIRTH

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

MEDICAL HISTORY QUESTIONNAIRE

Name:

DOB: **Age:**

What is your main reason for this visit? _____

Have you had prior evaluations or treatment for this problem? _____

__ I want aesthetic vaginal surgery.
___My labia rub, pull, tug on clothing.
___I have had unflattering comments about my genital region.
___I have had difficult births.
___I feel my vagina is falling down/sagging.
___I want TempSure Vitalia treatment.
___ Sex is uncomfortable/unpleasant.
___I am bothered by my decreased sexual sensation.
___I want Mona Lisa Touch.
___I want Viveve treatment.

Who were your referred by? _____

Obstetrical and Gynecological History:
Number of pregnancies _____ Number of Vaginal Deliveries _____ Number of C/S _____
Date of Last Menstrual Period: _____
Date of Last Pap Smear: _____ Was it normal or abnormal? _____

MEDICAL HISTORY:

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**
6. **_____**
7. **_____**

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

PAST SURGICAL HISTORY:

MEDICATIONS:

ALLERGIES AND REACTION:

SOCIAL HISTORY:

___ Married ___Divorced ___Single ___ Widowed Ethnicity: _____

What is your current occupation?

What is your highest level of education?

History of smoking Y/N Alcohol Y/N Illicit Substances Y/N

FAMILY HISTORY:

Reviewed with Patient: _____ Doctor's Initial / Date

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

WOMEN'S CENTER FOR PELVIC WELLNESS PATIENT QUESTIONNAIRE

Are you currently sexually active? Y/N

If yes, please answer the following questions.

HAVE YOU EVER EXPERIENCED THE FOLLOWING?		
Urine leakage especially when coughing, sneezing, jumping, etc.	☐Yes	☐ No
Disrupted sleep due to frequent trips to the bathroom	☐Yes	☐ No
Reduced sensation during intercourse	☐Yes	☐ No
Feeling of laxity during intercourse	☐Yes	☐ No
Feeling that the vaginal area is not as firm or tight as it once was	☐Yes	☐ No
A general sense of laxity in the vaginal area	☐Yes	☐ No
Tampons slipping	☐Yes	☐ No

HOW WOULD YOU RATE YOUR CURENT LEVEL OF VAGINAL LAXITY? CIRCLE ONE.

1 - Loose 2 - Moderately 3 – Slightly Loose 4 – Neither Loose nor Tight

5 – Slightly Tight 6 – Moderately 7 – Tight

Has this changed over time? _____

HAS A FEELING OF LAXITY AFECTED YOUR:		
Self-confidence	☐Yes	☐ No
Sexual self-image	☐Yes	☐ No
Interest in having sex	☐Yes	☐ No
Overall sexual enjoyment	☐Yes	☐ No
Other (please explain)	☐Yes	☐ No

DO YOU THINK SOME DEGREE OF LAXITY HAS AFFECTED YOUR PARTNER'S EXPERIENCE?	☐Yes	☐ No
ARE YOU BOTHERED BY THE APPEARANCE OF YOUR LABIA	☐Yes	☐ No
DO YOU EXPERIENCE DISCOMFORT, SUCH AS CHAFING DUE TO EXCESS OR LARGE LABIAL SKIN?	☐Yes	☐ No

Reviewed with Patient: _____

Doctor's Initial / Date

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)
PATIENT ACKNOWEDGEMENT FORM

Our notice of Privacy Practices provides information about how the Women's Center for Pelvic Wellness may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the lax. Please review our Notice thoroughly before signing this Acknowledgement Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contracting our office.
By signing this form, you acknowledge that our Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we strict how PHI about you is used or disclosed for treatment, payment or health care operations.

The patient understands that:

- **PHI may be disclosed or used for treatment, payment or health care operations.**
- **The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.**
- **The Practice reserves their right to change the Notice of Privacy Policies.**
- **The patient has the right to restrict the use of their PHI with insurance companies about tests or treatments for which they have paid for our-of-pocket.**
- **The patient has the right to obtain copies of their health information.**

I give permission for the Women's Center for Pelvic Wellness to:

_____Provide appointment conformations by phone, mobile text and email (Noe: This is only an automated reminder of your appointment. No clinical information will be released)

_____Share medical information with:

(1) Name: _____
Relationship: _____ Contact Number/s: _____

(2) Name: _____
Relationship: _____ Contact Number/s: _____

I assume responsibility to inform this Practice of any changes in the above information.

Patient's Printed Name: _____ Patient's Signature: _____

Relationship to patient): _____ Representative's Signature: _____
(If, other than patient)

Date: _____

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

PELVIC FLOOR DISTRESS INVENTORY (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 clicking 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 (POPDIi-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 incontinence 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

Reviewed with Patient: _____Doctor's Initial / Date

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

We are excited that you chose the Women's Center for Pelvic Wellness, office of Drs. Kimble and Tran as your health care provider. We pride ourselves on the relationship we develop with each patient and payment for all the services rendered is an important part of that relationship. Please take a moment to carefully read, initial and sign our financial policy.

Please bring the following with you at the initial visit and each visit thereafter if any changes have occurred:

1. Demographic information and insurance coverage card information.
2. Co-pay, Co-insurance payment, and payment for any uncovered services.
3. Referral, if required by your insurance or health group plan to see the physicians at the Women's Center for Pelvic Wellness. It is your responsibility to obtain the required referral or authorization and provide that to the office the day of your appointment. Otherwise, the initial visit cash fee is $350 and is due at the time of service. Contact our office if you need assistance with this process.

Guarantee of Payment:

Following the evaluation by the doctor, a bill will be generated and submitted to your insurance carrier on your behalf. An explanation of benefits and payment will be returned by your insurance, once the write-offs and other adjustments have been applied, or if the claim is denied, then you will be sent a bill for the balance. We can establish an acceptable payment plan with you and the office for any larger balances owed.

By signing the financial policies this expressly guarantees the payment of all fees and charges incurred by the patient that may not be covered by the insurance carrier. If payment is not received within 90 days, the delinquent account will be sent to collections for which the patient will be responsible for all costs incurred. Failure to pay for services in a timely manner will cause termination of your care with the practice. It may be possible to re-establish care in our office if the outstanding balance is paid in full.

Patient Initials_____

APPOINTMENTS

While we understand that life circumstances do occur that may require you to miss an appointment, it is expected that the patient reschedule her appointment at least 48 hours in advance of the scheduled appointment date. If such does not occur or the patient is a no show for the appointment, then a $50 fee may be assessed. We will make every attempt to reschedule your appointment at your convenience.

PROCEDURES AND SURGERIES

Any in-office procedure must be rescheduled at least 72 hours (3 business days) in advance or a fee of $100 may be assessed which also applies to any no shows.

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology

Any scheduled surgery must be cancelled/rescheduled at least 7 days in advance or a fee of up to $500 may be assessed. We fully understand the importance of your surgery and will make every effort to reschedule the surgery in a timely manner.

Patient Initials _____

Any in-office/and or surgical aesthetic procedure that has been agreed upon by you and your Doctor requires a $ 500 nonrefundable, transferable deposit at the time of scheduling.

Patient Initials _____

FORMS

Medical records : No charge

Disability/FMLA : $25

Patient Initials_____

The undersigned agrees that the financial policies have been read, fully understood and agrees to the terms of the policy.

_____ _____

Patient/Patient Representative Signature Date

_____

Printed Name

Women's Center for Pelvic Wellness
David M. Kimble, MD | Alexis May Tran DO
Female Pelvic Reconstructive Surgery and Urogynecology