

# *Southern Arizona Urogynecology Center*

## Pelvic Floor Medicine

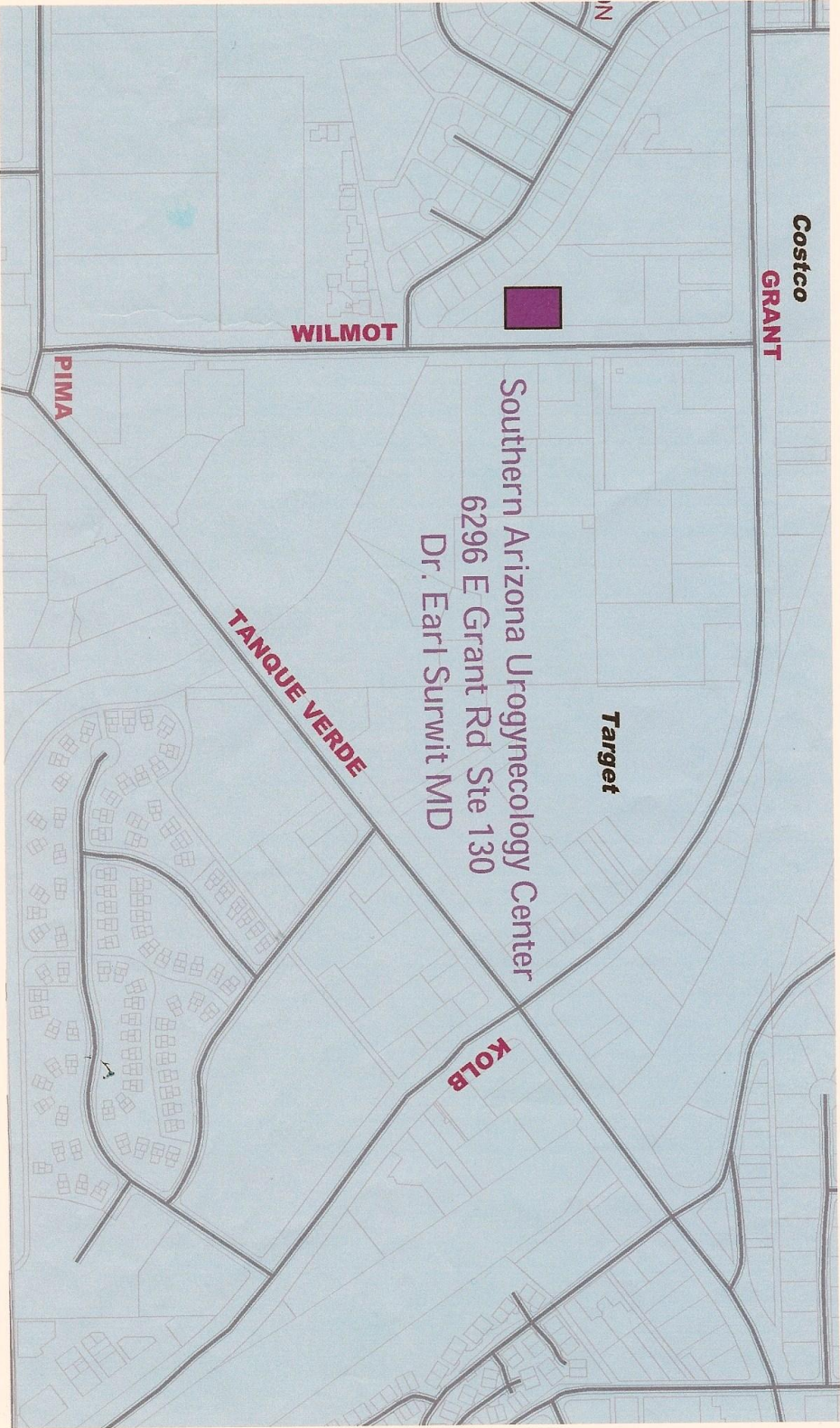
Thank you for calling and making an appointment with us. We will be happy to take care of you. Enclosed is a packet of personal and medical history sheets and HIPPA FORM (office regulations and practices). **Bring it completed along with your insurance card, your referral (if any is needed), and a picture identification.** If you should have any questions in regards to this packet please call us at 520-795-9300.

Thank you,

Customer Service Representative

NONSURGICAL MANAGEMENT  
OF INCONTINENCE AND  
PELVIC FLOOR DISORDERS

Earl Surwit, M.D.  
Rosa A. Garcia, B.S.N., N.P.  
6296 E. Grant Road, Ste. 130  
Tucson, Arizona 85712  
T (520) 520.795.9300  
F (520) 520.795.9305



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Dear Valued Patient:

Southern Arizona Urogynecology Center is leading the field in treatment for all types of incontinence. We offer a treatment plan that is unique in not just the region, but also nationwide. Our scheduling has been stretched out to where we are sometimes scheduling at least two months in advance. We ask that all patients give at least 24 hours notice if they are going to miss their scheduled appointments so that patients on the waiting list can be moved into those vacant positions. Patients may also be billed \$25 dollars for the cost of holding a treatment room open if they fail to call within the 24 hour time period to inform us they will be missing their appointment.

However, it is strongly recommended that you do not miss any of your scheduled pelvic floor therapies and urodynamics testing appointments as it may have an effect on the timeline and effectiveness of your treatment. This may necessitate adding additional therapies to your treatment schedule in order to ensure a successful outcome. Your insurance may not pay for the additional treatments, and you will be financially responsible for those additional treatments.

Additionally, if you do arrive more than 10 minutes late to your appointment, we reserve the right to cancel and reschedule your appointment depending on room availability. So, please give yourself enough time for travel and to find the office.

For those patients that repeatedly fail to call or show up for their appointments, it may be necessary to cancel them from our service. We apologize for the inconvenience of these measures, but they are necessary to ensure the fair treatment of this practice and its patients.

Sincerely,  
Southern Arizona Urogynecology Center

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I have read and understand the above.

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(Patient Signature)

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Date

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Tucson, AZ 85712

Telephone: (520) 795-9300

Fax: (520) 795-9305

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Please check all that apply to you as of today:

Fever \_\_\_\_\_

Constipation \_\_\_\_\_

Chills \_\_\_\_\_

Abdominal pain \_\_\_\_\_

Weight loss \_\_\_\_\_

Skin rashes or ulcers \_\_\_\_\_

Fatigue \_\_\_\_\_

Skin bruises \_\_\_\_\_

Appetite \_\_\_\_\_

Numbness in fingers or toes \_\_\_\_\_

Sinus infection \_\_\_\_\_

Swollen lymph nodes \_\_\_\_\_

Throat infection \_\_\_\_\_

Depression \_\_\_\_\_

Mouth ulcers \_\_\_\_\_

Anxiety \_\_\_\_\_

Hearing loss \_\_\_\_\_

Hospitalizations or illnesses \_\_\_\_\_

Ringling in the ears \_\_\_\_\_

Burning with urination \_\_\_\_\_

Chest pain \_\_\_\_\_

Blood with urine \_\_\_\_\_

Chest palpitations \_\_\_\_\_

Urinary frequency \_\_\_\_\_

Shortness of breath \_\_\_\_\_

Nocturia \_\_\_\_\_

Coughing \_\_\_\_\_

Urgency \_\_\_\_\_

Nausea \_\_\_\_\_

Increased incontinence \_\_\_\_\_

Vomiting \_\_\_\_\_

Decreased incontinence \_\_\_\_\_

Diarrhea \_\_\_\_\_

## OAB-V8

### Overactive Bladder-Validated 8-question Screener

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms. Please circle the number that best describes how much you have been bothered by each symptom. Add the numbers together for a total score and record the score in the box provided at the bottom.

How bothered have you been by...	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. Frequent urination during the daytime hours?	0	1	2	3	4	5
2. An uncomfortable urge to urinate?	0	1	2	3	4	5
3. A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
4. Accidental loss of small amounts of urine?	0	1	2	3	4	5
5. Nighttime urination?	0	1	2	3	4	5
6. Waking up at night because you had to urinate?	0	1	2	3	4	5
7. An uncontrollable urge to urinate?	0	1	2	3	4	5
8. Urine loss associated with a stronger desire to urinate?	0	1	2	3	4	5

Are you male?      If male  add 2 points to your score

Please add up your responses to the questions above

If your score is 8 or greater, you may have overactive bladder. There are effective treatments of this condition. You may want to talk with a healthcare professional about your symptoms.

Do you have problems with loss with exercise or coughing, laughing, sneezing?

"We can cure it without surgery in our office and it is covered by most insurances"

Name: \_\_\_\_\_

Date: \_\_\_\_\_

# Southern Arizona Urogynecology Center

## Pelvic Floor Medicine

### Personal Medical History

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

#### SOCIAL HISTORY:

Marital Status:     Single     Married     Separated/Divorced     Widowed

Tobacco Usage:     None     Current use     Prior Use    \_\_\_\_ year started    \_\_\_\_ year quit

Amount/Type \_\_\_\_\_ Number of years \_\_\_\_\_

Alcohol Use:    Beer / Wine / Spirits     Occasional/Rarely     Weekly     Daily

(circle one)    Estimated number of drinks per day/week \_\_\_\_\_

Are you or others you know concerned about your use of alcohol?     YES     NO

Your current medical condition: \_\_\_\_\_

List prescription and non-prescription medications you are taking: \_\_\_\_\_

Drug sensitivity and allergies (describe): \_\_\_\_\_

#### **Family History**

Have you ever been told you had one of the following?

Bladder Cancer \_\_\_\_\_    Lung disorder     yes     no    High blood pressure     yes     no  
Heart trouble     yes     no    Nervous disorder     yes     no

Disease or disorder of the digestive tract     yes     no

Colon Cancer \_\_\_\_\_    Any type of cancer     yes     no    If Yes what type: \_\_\_\_\_

Rectal Cancer \_\_\_\_\_    Disease of the kidney     yes     no    Diabetes     yes     no

Arthritis     yes     no    Hepatitis     yes     no

Ovarian Cancer \_\_\_\_\_    Malaria     yes     no

Breast Cancer \_\_\_\_\_    Disease or disorder of the blood? (describe) \_\_\_\_\_    Any vision or hearing disorders? (describe) \_\_\_\_\_

Others \_\_\_\_\_    Any physical defect or deformity? (describe) \_\_\_\_\_    Any life-threatening conditions? (describe) \_\_\_\_\_

Any contagious disorders? (describe) \_\_\_\_\_    Any other medical problems? (describe) \_\_\_\_\_

Any previous surgeries? (describe) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NONSURGICAL MANAGEMENT  
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### **Patient Information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Sex: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Number: \_\_\_\_\_  
Social Security#: \_\_\_\_\_ City of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Number: \_\_\_\_\_

### **Insurance Information:**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### **Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment to assume the costs of interest, collections and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Earl A. Surwit, M.D. I also authorize agents of any hospital, treatment center or previous physicians to furnish Earl A. Surwit, M.D. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports to my treatment to any insurance carrier as needed.
3. My right to payment for all treatments is hereby assigned to Earl A. Surwit, M.D. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Earl A. Surwit, M.D.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) representatives and agents of my health benefit plan; (c) persons conducting quality or peer review or patient satisfaction surveys.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Responsible Party Signature Relationship Date

# Southern Arizona Urogynecology Center

Pelvic Floor Medicine

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize Earl Surwit, M.D. to release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

- Healthcare information related to the following treatment, condition, of dates:  
\_\_\_\_\_
- All healthcare information
- Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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## **NOTICE OF PRIVACY PRACTICES**

**To our patients.** This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

- \* How we may use and disclose your health information
- \* Your privacy rights
- \* Our obligation concerning the use and disclosure of your health information

### **We may use and disclose your health information in the following ways**

The following categories describe the different ways in which we may use and disclose your health information.

1.) **Treatment.** Physicians and staff may use or disclose your health information in order to treat you or assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents.

2.) **Payments.** Our practice may use your health information to bill and collect payment for the services you received from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose this information to obtain payment third parties that maybe responsible for such cost, such as family members. Also, we may use your health information to bill you directly for services and items.

3.) **Health care operations.** We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and effectively as possible. This could be used to evaluate the performance of our physicians and staff, to determine if our treatment plans are effective, or determine if there are other services we should be offering. We may also compare our clinical data with other practices, review it with medical students, medical faculty, technicians, and others for teaching and learning purposes. We will strive to remove information that identifies you from this medical information.

4.) **Disclosures required by law.** Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.

5.) **Appointment Reminders and Sign-In Sheets.** We may want to call you by phone for appointment reminder purposes. Please advise us if you DO NOT want us to call and leave appointment reminder messages at your home, possibly on your answering machine, or with any co-worker at your place of work. We may also use a "Sign-In" sheet at the front desk, for purposes of logging our patients as they arrive.

### **Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

- 1.) To public health authorities and health oversight agencies that are authorized by law to collect information.

- 2.) *Lawsuits and similar proceedings in response to a court administrative order.*
- 3.) *If asked to do so by law enforcement official.*
- 4.) *When necessary to reduce or prevent as a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to person or organization able to help prevent the threat.*
- 5.) *If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.*
- 6.) *To federal officials for intelligence and national security activities authorized by law.*
- 7.) *To correctional institutions or law enforcement officials if you are an inmate or under the the custody of a law enforcement official.*
- 8.) *For Workers Compensation and similar programs.*

**Your rights regarding your health information**

1.) **Communications.** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2.) **You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations.**

*Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.*

3.) *You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records and billing records, but not including psychotherapy notes. You must submit your request in writing to our PRIVACY OFFICER.*

4.) **You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice.** To request an amendment, your request must be made in writing and submitted to our PRIVACY OFFICER.

5.) *Right to a copy of this notice. You are entitled to receive a copy of this notice of privacy practices. You may ask us to give you a copy of this notice, contact our PRIVACY OFFICER.*

6.) **Right to file a complaint.** *If you believe that your privacy rights have been Violated, you may file a complaint with our practice's PRIVACY OFFICER, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing, and you will not be penalized for filing a complaint.*

7.) **Right to provide an authorization for other uses and disclosures.** *Our practice will obtain written permission from you to disclose information in ways that have not been identified in this notice, or are not permitted by these laws. **CONTACT OUR PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS.***

**WITH THIS SIGNATURE, I ACKNOWLEDGE THAT I HAVE BEEN GIVEN COPY OF THE PRIVACY NOTICE FOR THIS PRACTICE**

---

**Signature**

**Printed Name**

**Date**