Dr. Theodore V. Benderev Dr. Kym A. Kanaly Dr. Patricia A. Wallace
26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
949.364.4400 Fax: 949.364.2829

Dear Valued Patient:

Thank you for choosing to schedule your appointment with our office for your health care needs. Our commitment to quality and to our patients governs every aspect of our work. We believe in providing technically advanced treatment with personalized attention and welcome you to our Practice.

Enclosed please find the information packet necessary to complete your chart. In order to serve you in a timely manner, we ask that you **complete the information PRIOR** to your appointment scheduled on_____, at_____ and **bring** this information back with you at the time of your appointment. If your paperwork is incomplete or forgotten, you may arrive 30 minutes early to fill out paperwork or we will likely have to reschedule your appointment.

Please bring with you your insurance card and driver's license or photo ID. Deductibles and co-payments are due and will be collected at the time of your visit. You will be responsible for payment at the time of service if you arrive without your insurance card. We are contracted with Medicare and most PPO insurance plans. We are contracted with three HMO's: 1) Memorial Care Medical Group, 2) Mission Hospital Affiliated Physicians and 3) Mission Heritage. We do not verify benefits nor check eligibility prior to your appointment. To avoid insurance or contracting issues, we strongly encourage you to contact your insurance plan and verify your benefits, eligibility and verify that the doctor you are seeing is a contracted provider and is in network prior to seeking treatment. Your insurance is a contract between you and your carrier. Our staff will assist you to the best of their ability in dealing with your insurance company, but it is your responsibility to know and understand your insurance policy and coverage of your plan before you arrive for your visit.

We are located in the Mission Medical Tower. Our office can be reached by turning at Los Altos off of Crown Valley Parkway. Paid parking is available in the covered parking structure and surrounding areas behind our building. Please note we are tenants of Mission Hospital and there is a fee when parking on its campus. As such, we do not validate parking.

Please feel free to call us at (949) 364-4400 and select option 2, if you have any questions or visit our website at www.urology-gynecology.com. Thank you for choosing our office. We look forward to serving you.

The Incontinence and Pelvic Support Institute
A Medical Corporation

Patient: _____ **Date:** _____

MALE MEDICAL HISTORY

Please **circle** any illnesses that you have:

[ ] **I have no medical problems**

Alcoholism
Alzheimer's Disease
Anxiety
Arthritis
Asthma
Attention Deficit Hyperactivity Disorder
Bleeding Disorders
Cancer, Type:
_____
Cerebrovascular Accident (Stroke)
Cervical Disc Herniation
Chronic Cough
Deep Vein Thrombosis
Depression
Diabetes
Epididymitis
Fibromyalgia
Gastroesophageal Reflux Disease
Glaucoma
Heart Disease
Hepatitis
Hyperparathyroidism
Hypertension
Hypothyroid
Lumbar Disc Disorders
Multiple Sclerosis
Myocardial Infarction (MI)
Parkinson's Disease
Prostate Cancer
Prostatitis
Renal Calculi
Rheumatic Fever
Spinal Cord Injury

Other medical problem(s), Type:
_____
_____
_____

SURGICAL HISTORY Please **circle** any surgeries that you have had:

Abdominal Surgery, Type:
_____
Appendectomy
Back Surgery
CABG X _____ vessels
Other Cardiac Surgery
Cholecystectomy (removal of the gall bladder)

Facial Surgery, Type:
_____
Hip Surgery
Knee Surgery
Laminectomy
Prostate Surgery
Tonsillectomy

Any Other Surgery, Type:
_____
_____
_____

MEDICATIONS

Name	Dosage (e.g. mg, gm, cc)	When during day	When started

ALLERGIES: (include medications, iodine, seafood and latex) **REACTION**

_____
_____
_____
_____
_____

The Incontinence and Pelvic Support Institute
A Medical Corporation

Patient: _____ **Date:** _____

FAMILY HISTORY

Please indicate illnesses these family members have had:

Maternal (Mother): _____ Daughter: _____ Sister: _____

Paternal (Father): _____ Son: _____ Brother: _____

Adopted: Yes No

SOCIAL HISTORY

Please circle or fill out the appropriate answer(s):

Marital Status: Single Married, happily - Yes No Separated Divorced Remarried Widowed

Number of Children: From this marriage: ____ From any prior marriage: ____

Employment: Vocation: _____ Employed Unemployed Retired Student

Tobacco: Has never smoked

Quit smoking: less than 5 years ago 5 to 10 years ago more than 10 years ago

Number of Years using tobacco _____ Number of Cigarettes per day: 1 5 10 20 30 40

Frequency of Drinks (alcohol): Never drinks Drinks rarely Drinks per day: 1 2 more than 2

Use of Illicit Drugs: Never In the past only Currently

Uses marijuana Uses cocaine

HEALTH MAINTENANCE

Most recent PSA: Month and Year: _____ Result: _____

REVIEW OF SYSTEMS:

Please circle all symptoms that you currently have:

Constitutional
Chills
Fever
Weight Gain

Eyes
Blurred Vision
Double Vision

Ears/Nose/Throat/Neck
Dry Mouth
Hearing Loss
Sore Throat

Cardiovascular
Chest Pain
Palpitations
Edema (swelling), location:
_____

Respiratory
Cough
Dyspnea
Dry Cough
Productive Cough

Gastrointestinal
Anorexia
Heartburn
Abdominal Pain
Nausea
Vomiting
Constipation
Diarrhea
Fecal Urgency
Incontinence of Stool
Rectal Bleeding
Black Stool

Genitourinary / Nephrology
Dysuria (burning with urination)
Hematuria (blood in urine)
Urinary Incontinence
Prostatitis

Musculoskeletal
Joint aches (arthralgias)
Back Pain
Gait abnormality (difficulty walking)
Hip Pain
Myalgias (muscle ache)
Neck Pain

Dermatologic
Rash, location:
_____

Neurologic
Confusion
Dizziness
Headaches
Impaired Balance
Memory Loss
Numbness, location:
_____
Parasthesias (funny feeling on your skin) location: _____

Psychiatric
Anxiety
Depression
Easily Distractable
Inability to Concentrate

Endocrine
Alopecia (loss of hair), location:
_____
Change in sex drive (libido)
Drinking large amounts of fluids (polydipsia)

Hematologic
Easy Bleeding
Easy Bruising

Allergy / Immunology
Nasal Drainage

Patient: _____ **Date:** _____

Male Genital History

(covering scrotal or testicular masses, pain and swelling; sexual dysfunction)

What is <u>your chief complaint</u> (the main complaint that brought you in today):

_____

Please <u>circle and fill out</u> the following:

<u>If you have scrotal or testicle problems:</u>

Which of the following do you have?

Testicular Pain — Scrotal Pain

Testicular Mass — Scrotal Swelling

On which side is your complaints? Right Left Both

How did you find the abnormality?

Found on self-exam Found by partner Found by another physician

Do you have any redness of the scrotum? Yes No

Does it burn when you urinate? Yes No

On average, how often do you urinate? Every ____ hours

Do you have a strong urge before you urinate? Yes No

Do you have a reduced force of urinary stream? Yes No

Have you had any recent fever? Yes No

Have you seen blood in your urine? Yes No

Have you noticed any breast enlargement? Yes No

Do your symptoms interfere with sexual activity? Yes No

Please <u>circle</u> any of the following that <u>worsen</u> your symptoms:

Direct Pressure	Sexual activity	Standing
Tight Clothing	Sitting	Bike Riding

<u>If you have sexual problems:</u>

Do you have an inability to initiate an erection? Yes No

Have you stopped having erections at night? Yes No

Have you stopped having erections with self-stimulation? Yes No

Are you unable to complete intercourse? Yes No

Are you bothered by a reduced sex drive? Yes No

Patient: _____ **Date:** _____

All patients to continue filling out:

How quickly did your symptoms come on? Gradually Sudden

When did your symptoms begin? ___ hours / days / weeks / months / years ago

How often are your symptoms? Constant Intermittent

How have your symptoms changed? Worsening Unchanged Improving Resolved

TREATMENTS: Please check as appropriate.

	Previously used?	Was it successful?	Currently used?
Rest	_____	_____	_____
Scrotal elevation	_____	_____	_____
Ice Packs	_____	_____	_____
MEDICATION			
Nonsteroidal anti-inflammatory	_____	_____	_____
Non-Opioid Analgesics			
Opioid Analgesics			
Trimethoprim-Sulfamethaxazole (Bactirm, Septra)	_____	_____	_____
Amoxacillin	_____	_____	_____
Augmentin	_____	_____	_____
Cepalosporin	_____	_____	_____
Doxycycline	_____	_____	_____
Tetracycline	_____	_____	_____
Cipro	_____	_____	_____
Levaquin	_____	_____	_____
Viagra (sildenafil)	_____	_____	_____
Cialis (tadalafil)	_____	_____	_____
Levitra (vardenafil)	_____	_____	_____
Muse (alprostadil)	_____	_____	_____
Caverject (alprostadil)	_____	_____	_____
SURGERY			
Epididymectomy (Removal of epididymis)	_____	_____	_____

Previous evaluation for your genital problem:

Performed by M.D. – Name: _____

When performed: ____ days ago ___wks ago ___ months ago ___ yrs ago

Studies performed: Scrotal Ultrasound Yes No
Serum Testosterone Yes No

THEODORE V. BENDEREV, M.D. KYM A. KANALY, M.D. PATRICIA A. WALLACE, M.D.

LEGAL NAME - FIRST: _____ LAST: _____ MI: _____

STREET, CITY, ZIP: _____

HOME PHONE: ( ) _____ CELL: ( ) _____ EMAIL: _____

SOCIAL SECURITY: _____ DATE OF BIRTH: _____ GENDER: F M

EMPLOYER: _____ JOB TITLE: _____

WORK PHONE: ( ) _____ ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

YOUR PRIMARY CARE PHYSICIAN: _____ PHONE: ( ) _____

WHO REFERRED YOU TO OUR OFFICE: _____

ADDRESS, CITY, STATE, ZIP: _____

LEAVE BLANK IF YOU DO NOT WISH TO REPORT THE FOLLOWING: PREFERRED LANGUAGE: _____

NATIONALITY (CITIZENSHIP): _____ ETHNICITY: _____ RACE: _____

REQUIRED TO FILL PRESCRIPTIONS: *(IF LEFT BLANK WILL DEFAULT TO TOWER PHARMACY)*

PHARMACY NAME: _____ PHONE: ( ) _____

ADDRESS, CITY: _____ FAX: ( ) _____

PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE TO YOUR APPOINTMENT.
IF YOU DO NOT HAVE PROOF OF INSURANCE - PAYMENT IS REQUIRED
AT THE TIME SERVICE IS RENDERED. WE CAN MAKE NO EXCEPTIONS.

RESPONSIBLE PARTY (OTHER THAN PATIENT)

FIRST NAME: _____ LAST: _____ MI: _____

RELATIONSHIP TO PATIENT: _____ DRIVERS LICENSE #: _____

DATE OF BIRTH: _____ EMPLOYER: _____

EMERGENCY CONTACT

NAME: _____ PHONE : ( ) _____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE INCONTINENCE & PELVIC SUPPORT INSTITUTE (IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH HIPAA REGULATIONS.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A $5.00 MONTHLY FEE FOR BILLING SERVICE, PLUS INTEREST. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT IF MINOR): _____

DATE: _____

THEODORE V. BENDEREV, M.D. KYM A. KANALY, M.D. PATRICIA A. WALLACE, M.D,

FINANCIAL POLICIES

We welcome you to our office. We are able to concentrate on the practice of medicine and provide quality care by having our financial policies understood by our patients and by avoiding confusion or misunderstandings.

Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. We will bill insurance claims with a maximum of two insurance carriers per patient. It is important to emphasize that your insurance is a contract between you and the insurance carrier. Insurance plans and contracts change constantly. It is your responsibility to contact your insurance company and verify your benefits and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we have not been paid by your insurance carrier within 45 business days.

_____ **(patient's initials)**

Drs. Benderev, Kanaly and Wallace are participating physicians with Medicare and accept assignment for all covered Medicare services. Medicare pays 80% of approved charges and the patient is responsible for the other 20%, after the annual deductible is met. Our office staff will bill secondary insurance if the responsible party has given permission to the insurance company to have the payment sent to us. Each physician reserves the right to accept Medi-Medi and accept the Medicare payment portion as payment in full.

Drs. Benderev, Kanaly and Wallace are not participating physicians with Medi-Cal and therefore, cannot accept Medi-Cal insurance (including retro-active Medi-Cal coverage). For patients without insurance plans or for patients that are unable to provide an insurance card verifying current coverage, we require payment at the time services are rendered. If you do not have insurance or your insurance company does not pay for services rendered it is the patient's responsibility for payment in full. This also applies to patients requesting services that have insurance plans with which we are not contracted, (e.g., out-of-network coverage).

_____ **(patient's initials)**

All services rendered by Drs. Benderev, Kanaly and Wallace that are not a covered benefit of your insurance policy are your responsibility to pay. Any patient that is seen or treated without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively. All monies owed by the patient (e.g. co-payments, deductibles, required "out-of-pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered.

_____ **(patient's initials)**

If your account is placed with a collection agency, due to non-payment, you will be responsible for any additional charges this may incur, including a monthly interest and penalty fee, collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due.

_____ **(patient's initials)**

While we understand there may be times when our patients need to cancel their appointments, we have found it necessary to implement a "Cancellation and No-Show Policy". Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show." A no-show patient scheduled for an office visit may be charged $40.00. A no-show patient scheduled for a procedure or diagnostic test may be charged $100.00. No-show charges are not billable to your insurance company and are your responsibility to pay.

_____ **(patient's initials)**

We are willing to work with any patient requesting a financial payment plan. <u>There will be a $45 charge for each check that is returned for insufficient funds.</u>

We hope you find this information helpful. Please feel free to ask our office staff if you require any further assistance.

Patient Signature: _____ **Date:**_____

Theodore V. Benderev, M.D. Kym A. Kanaly, M.D. Patricia A. Wallace, M.D.
26732 Crown Valley Parkway, Suite 327 * Mission Viejo * CA * 92691 * 949.364.4400

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that applies):

___ Home Telephone _____ ___ Email Address _____

___ O.K. to leave detailed message, including clinical information with spouse, family member, and/or on voicemail.
___ Leave message with call back number only.

___ Cell Telephone _____

___ O.K. to leave detailed message, including clinical information on voicemail.
___ Leave message with call back number only.

___Work Telephone _____

___ O.K. to leave detailed message, including clinical information on voicemail.
___ Leave message with call back number only.

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.

TEXTING

Is it ok if we text you on occasion, for reasons including appointment reminder, and patient/feedback?

☐ **Yes** ☐ **No**

PRIVACY PRACTICES ACKNOWLEDGEMENT

NOTE: A copy of our Privacy Practices Policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name _____ **Birth Date** _____

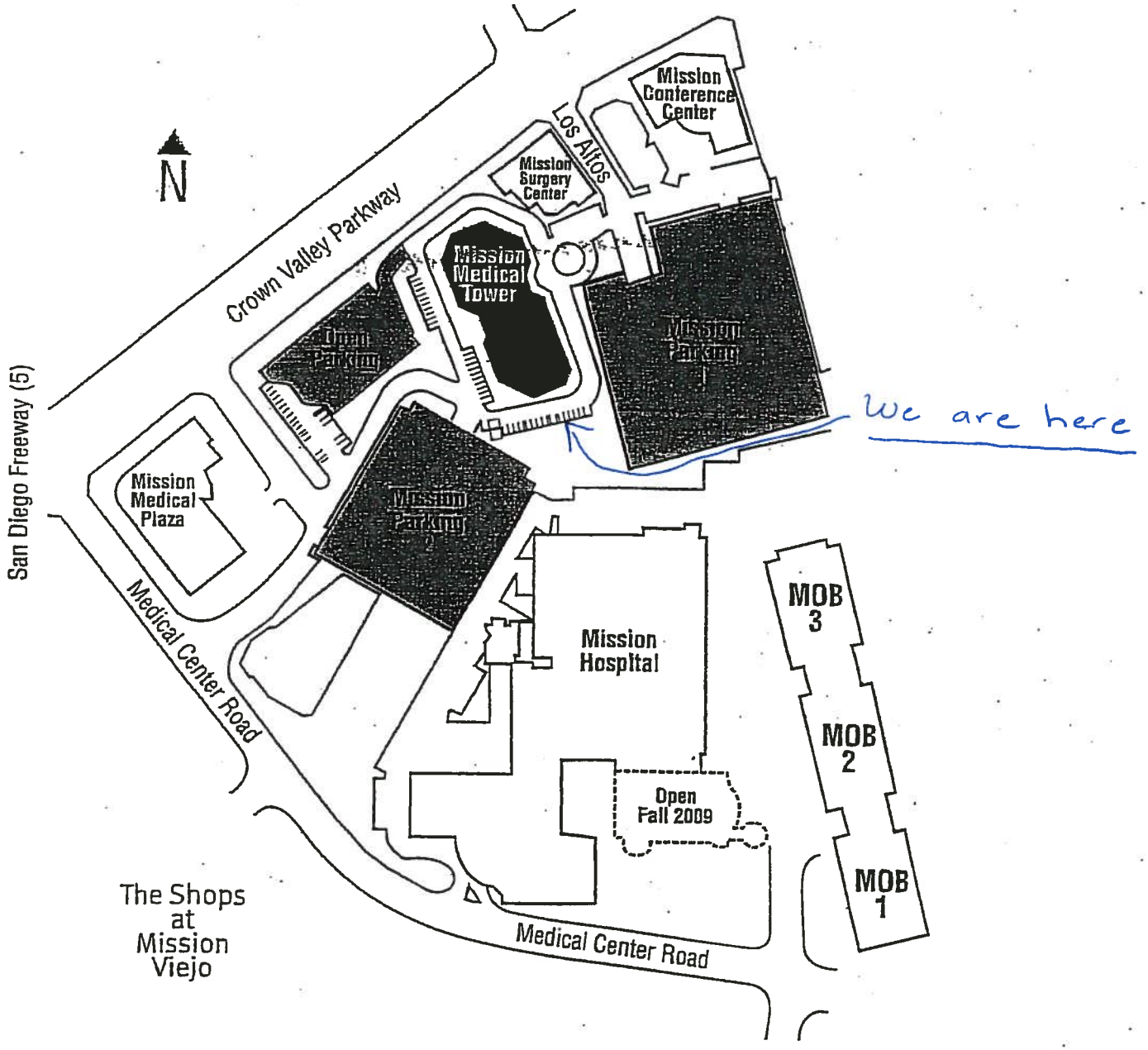
Signature _____ **Date** _____

NOTE: This request supersedes any prior request I may have made for confidential patient record disclosures.

We are located at

26732 Crown Valley Pkwy
Suite # 327
Mission Viejo, CA
92691

Phone 949 364-4400



Mission Campus Map

Theodore V. Benderev, M.D.

Patricia A. Wallace, M.D.

Kym A. Kanaly, M.D.

Telephone Extensions to Help Our Patients Navigate Our Phone System

Phone number: **949.364.4400**

ONCE THE GREETING BEGINS SELECT ONE OF THE FOLLOWING EXTENSIONS:

APPOINTMENT SCHEDULING/RECEPTION – select **101 OR 102**

MEDICAL ASSISTANT or for **REFILLS** and **TEST RESULTS** select **107**

SURGERY SCHEDULER and **AUTHORIZATON SPECIALIST**, select **104**

MEDICAL RECORD SPECIALIST, select **103**

BILLING OFFICE, select **949.436.0014**

MANAGER/ADMINISTRATION select **106**

Please leave a message if your party does not answer. Be sure to leave your full name, date of birth and a phone number where you can be reached.

Messages received before 4:30 pm Monday – Thursday will be returned before the close of the business day. Our office closes at 1:30 on Fridays. Messages received before 1:00 pm on Friday, will be returned before the close of the business day.