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.

Patient: ______________________ **Date:** ______________

Male Urinary History

(covering burning, prostatitis, cystitis, urinary frequency, urgency, incontinence, obstruction, blood in the urine)

What is your chief complaint (the main complaint that brought you in today):

____

Please answer the following questions by circling the appropriate numbers in the shaded area:

	NOT AT ALL	LESS THAN 1 TIME IN FIVE	LESS THAN HALF THE TIME	ABOUT HALF THE TIME	MORE THAN HALF THE TIME	ALMOST ALWAYS	Total
How often do you urinate **more than every two hours**?	0	1	2	3	4	5	Freq
How often do you find it **difficult to postpone** urination?	0	1	2	3	4	5	Urge
How often do you have a **weak urinary stream**?	0	1	2	3	4	5	Stream
How often do you push or **strain** to begin urination?	0	1	2	3	4	5	Strain
How often do you find that you **stop and start** again when you urinate?	0	1	2	3	4	5	Interm
How often do you have a sensation of **not emptying** your bladder after urination?	0	1	2	3	4	5	PVR
How many times do you typically **get up to urinate** when you go to bed at night?	0	1 Time	2 Times	3 Times	4 Times	5 or more times	Noct

QUALITY OF LIFE DUE TO URINARY SYMPTOMS	Delighted	Pleased	Mostly Satisfied	Mixed: equally satisfied & dissatisfied	Mostly Dissatisfied	Unhappy	Terrible
How would you feel about spending the rest of your life with your urinary condition just the way it is now?	0	1	2	3	4	5	6

Please circle and fill out the following:

Does it burn when you urinate? Yes No

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

How many times do you get up at night to urinate? _____ times

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

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

Do you leak urine (incontinence)? Yes No

Have you seen blood in your urine? Yes No

Have you been told that you have microscopic blood in your urine (blood not visible by the eye)? Yes No

Patient: ______________________ **Date:** ______________

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

How quickly did your symptoms come on? Gradually Sudden

How often are your symptoms? Constant Intermittent

How severe are your symptoms? Mild Moderate Severe

How have your symptoms changed? Worsening Unchanged Improving Resolved

Please circle which of the following worsen your symptoms:

Caffeine
Alcohol
Diuretics
Decongestant / Cold Medication
Increased fluid intake
Stress
Sexual activity

Circle if you have had: Radical Prostatectomy Radiation Therapy to the Pelvis

Do you have a feeling of incomplete bladder emptying Yes No

Have you had any recent fever? Yes No

Have you had repeated urinary tract infections? Yes No

If you have pain, circle any of the pain locations:

Back Lower abdomen (above pubic bone) Lower back Kidney area (mid back)

If you are bothered by Urinary Leakage, please fill out:

(otherwise, go directly to "Treatments" on the next page)

Do you leak urine with activity? Yes No

Do you leak urine associated with urgency? Yes No

If you don't use pads,
please describe the amount of urine loss:
[ ] Small resulting in damp underwear
[ ] Moderate, resulting in wet underwear
[ ] Large, going through clothes

If you use pads, how many pads do you, on average, use in a day? ___ pads /day

What type of pads do you usually use? Light Medium Heavy

Patient: ______________________ **Date:** ______________

TREATMENTS: Please <u>check</u> as appropriate.

	Previously used?	Was it successful?	Currently used?
Kegel Exercises			
Biofeedback training			
Physical Therapy			
Acupuncture			
Medications			
Flomax (tamsulosin)			
Uroxatrol (alfuzosin)			
Proscar (finasteride)			
Avodart (dutasteride)			
Levaquin (levofloxacin)			
Cipro (ciprofloxacin)			
Trimethoprim-Sulfamethaxazole (Bactirm, Septra)			
Nitrofurantion (Macrobid)			
Amoxicillin			
Cepalosporin			
Doxycycline			
Prophylactic antibiotics			
Antispasmodics			
Oxybutynin (Ditropan)			
Oxybutynin Patch (Oxytrol)			
Oxybutynin Gel (Gelnique)			
Tolterodine (Detrol)			
Darifenacin (Enablex)			
Solifenacin (Vesicare)			
Trospium (Sanctura)			
Elmiron			
Surgeries:			
Laser Prostatectomy			
Transurethral Microwave Therapy			
Transurethral Prostate Resection			
Sling procedure			
Artificial Sphincter			
Interstim			

Patient: ______________________ **Date:** ______________

<u>Previous evaluation</u> for your urinary problem:

Performed by a: Name of M.D.

Family M.D. ______________________

Internist ______________________

Urologist ______________________

Studies performed:

Study		
Urine Analysis	Yes	No
Recent Urine Culture	Yes	No
Urine Cytology	Yes	No
Prostate Specific Antigen (PSA)	Yes	No
Abdominal Ultrasound	Yes	No
One Abdominal X-ray (KUB)	Yes	No
Intravenous Pyelogram (IVP)	Yes	No
Abdominal or Pelvic CT Scan	Yes	No
Abdominal or Pelvic MRI	Yes	No
Cystoscopy	Yes	No
Urodynamic Testing	Yes	No
Prostate Biopsy	Yes	No

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

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** _______________________

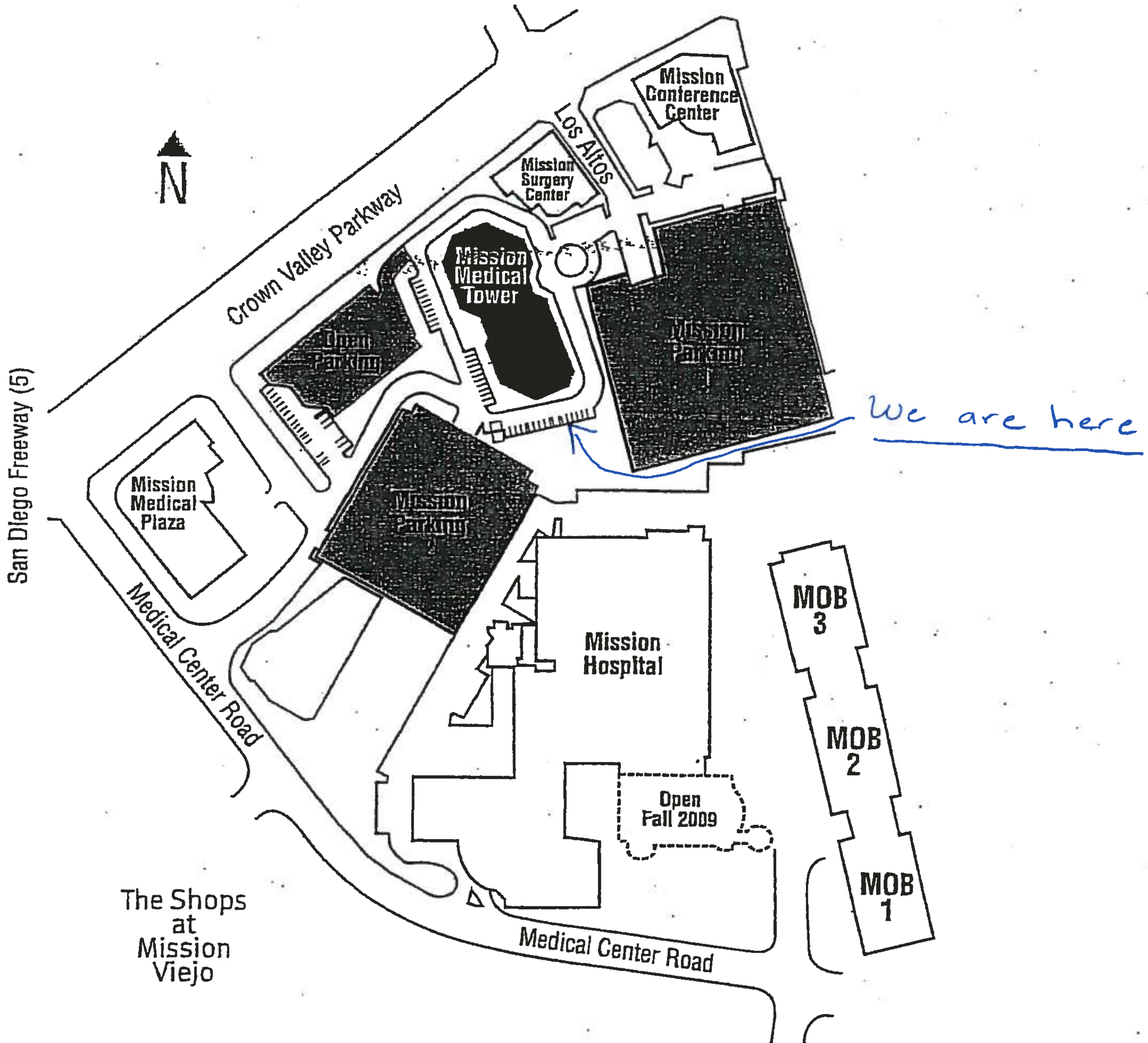
NOTE: This request supersedes any prior request I may have made for confidential patient record disclosures.

F:/Documents/Hipaa Patient Record of Disclosures and Privacy Practices Acknowledgement 062212

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.