THEODORE BENDEREV, M.D.

CERTIFIED BY THE AMERICAN BOARD OF UROLOGY
PHONE: 888-VASECTOMY (1-888-827-3286)

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

341 Magnolia, Suite 206
Corona, CA 92879

Dear _____:

Thank you for choosing to schedule your appointment with Dr. Theodore Benderev for your vasectomy.

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 and **bring** this information back with you at the time of your appointment. **Please do not mail these forms back to our office.** 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. 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. 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. If you are choosing to use your Point of Service or Out of Network Options, we recommend that you contact your insurance carrier prior to coming to our office and notify them that you are using this option for our doctors.

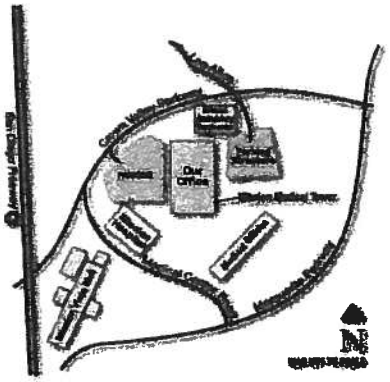
For your convenience, I have 2 office locations. My Mission Viejo office is located at 26732 Crown Valley Parkway (in the Mission Medical Tower) in Suite #327. Paid parking is available in the covered parking structure. Our office can be reached by turning at Los Altos off of Crown Valley Parkway. (See diagram below.) We do not validate parking. For directions to my Corona office, please go to vasectomycorona.com and click on "Contact Us". Please feel free to call us at 888-VASECTOMY if you have any questions.

Please remember to wear long pants and wear an athletic supporter (jock strap) or tight briefs when you arrive for your procedure. Make sure that you have a light meal on the morning of the procedure.

Your appointment is on _____ at _____.

Thank you for choosing us for your vasectomy and we look forward to serving you!

Theodore Benderev, M.D



THEODORE V. BENDEREV, M.D.

PATIENT INFORMATION SHEET - PLEASE COMPLETE IN ITS ENTIRETY

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 INSURED PARTY: (IF 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 DOCTOR WHOSE NAME APPEARS ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I HEREBY AUTHORIZE THEODORE BENDEREV, M.D. TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THORUGH 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. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME THE SERVICE IS RENDERED IF I DO NOT PRESENT WITH A VALID INSURANCE CARD & DRIVER'S LICENSE. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT OF MINOR): _____

DATE: _____

THEODORE V. BENDEREV, 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 is a participating physician with Medicare and accepts 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.

Dr. Benderev is not a participating physician 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 Dr. Benderev that is not a covered benefit of your insurance policy is 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. There will be a $45 charge for each check that is returned for insufficient funds.

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.

Theodore Val Benderev, M.D.
Urology
PHONE: 888-VASECTOMY (1-888-827-3286)

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

341 Magnolia, Suite 206
Corona, CA 92691

PATIENT VASECTOMY QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Referred by: _____ **Age:** _____ **years old**

Describe the health care that you are seeking today:

(Chief Complaint) _____

VASECTOMY HISTORY

Have you had an infection in the testicle area? Yes No

Have you had prostatitis? Yes No

If yes, what medication were you treated with and for how long?

_____

_____

Have you ever been injured in the scrotal area? Yes No

If so, describe_____

Have you ever had an inguinal hernia repair? Yes No

Are you having sexual problems? Yes No

Does your wife / partner wish for you to have a vasectomy? Yes No

Is there anyone in your family who has had prostate cancer?
Yes No

If so, which relative was is he? _____

Have you had any conditions affecting the urine, kidneys, bladder, prostates, testicles or penis?

_____

How long ago did you first consider a vasectomy?

___ weeks ago ___ month(s) ago ___ year(s) ago

Please indicate if you have reviewed information on either of these two websites:

[ ] Vasectomy.MD [ ] Vasectomy.com

What, if any, additional questions or concerns do you have?

_____

Past Illnesses – please circle all that apply and list others:

NONE [ ]	Heart disease	Myocardial Infarction (MI)
	Hepatitis	Cancer, type_____
Bleeding Disorder	Hypertension	Renal Stones
Diabetes	Hypothyroidism	Other: _____

Past Surgeries – list any operations you have had and the year of each procedure

NONE [ ]

_____

_____

Medications – list all prescription and non-prescription medications you use **with their doses**:
(include aspirin, hormones, birth control pills, laxatives, vitamins, calcium and others)

NONE [ ]

_____

_____

_____

Patient Name: ____ **Date:** ____________________

ALLERGIES (include medication, iodine, seafood, latex & others) **REACTION**

NONE [ ]

____

____

Your Family's Medical History – list illnesses of your blood relatives (include heart disease, diabetes, high blood pressure, bleeding problems)

Living relations	**Illness**	**Deceased relations**	**Illness/Cause of death**

Social History – please circle or fill in the blank.

Marital status: Single Married Divorced Separated Widowed Remarried

Your occupation: ______________________ Are you retired? Yes No

How long have you been in your current relationship? ____ months / years

Is your relationship stable? Yes No

How many children do you have? ______ Age Range ______________

Are they generally healthy? Yes No

Tobacco use: Never Past: less than 5 years ago 5-10 years ago

Presently more than 10 years ago

Alcohol use: ___ drinks per week rarely never drink

Review of Systems

Please circle all symptoms that you currently have:

NONE [ ]

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

PRECAUTIONS FOR VASECTOMY

All patients anticipating outpatient or hospital procedures and/or surgery must stop taking aspirin and aspirin-containing products as well as any anti-inflammatory drug for **10 days** prior to procedure. Aspirin, some anti-inflammatory drugs and some herbal medicines can cause bleeding problems during and following the procedure. Always check with your doctor about your specific medications.

THE FOLLOWING LIST CONTAINS SAMPLES OF COMPOUNDS TO BE AVOIDED:

Advil	Coricidin	Haltran	Robaxisal
Alka Seltzer	Damason	Ibuprofen	Sine-Aid
Alleve	Darvon Compound	Indocin	Sine-Off
Anacin	Dristan	Measurin	Stendin
Ascriptin	Duragesic	Mediprin	Supac
Aspirin	Ecotrin	Midol	Synalgos Caps
Bayer Aspirin	Empirin	Motrin	Synalgos D.C.
Bufferin	Eosprin	Naprosyn	Tolectin
Butalbital	Equagesic	Norgesic	Toradol
Celebrex	Excedrin	Nuprin	Triaminicin
Cheracol Caps	Fiorinal	PAC	Vanquish
Congespirin	Four Way Cold Tabs	Panalgesic	Zomax
Cope	Halfprin	Percodan	

ALSO AVOID "HERBAL" COMPOUNDS PRIOR TO SURGERY.

A number of herbal remedies have side effects that could complicate surgical procedures by inhibiting blood clotting, affecting blood pressure, or interfering with anesthetics. Ginkgo biloba, feverfew, garlic, ginger, and ginseng have all been shown to interfere with the function of platelets - necessary for clotting. The use of herbal preparations in the United States has risen dramatically over the past decade. Although we do not have the exact rate of complications form herbs, the potential for them to cause a problem is real.

HERBAL MEDICINES TO AVOID (not an all-inclusive list)

Black Cohosh	Fish Oil	Ginger	St. John's Wart
Echinacea	Flaxseed Oil	Ginkgo Biloba	Valerian
Ephedra	Garlic	Kava	
Feverfew	Ginseng		

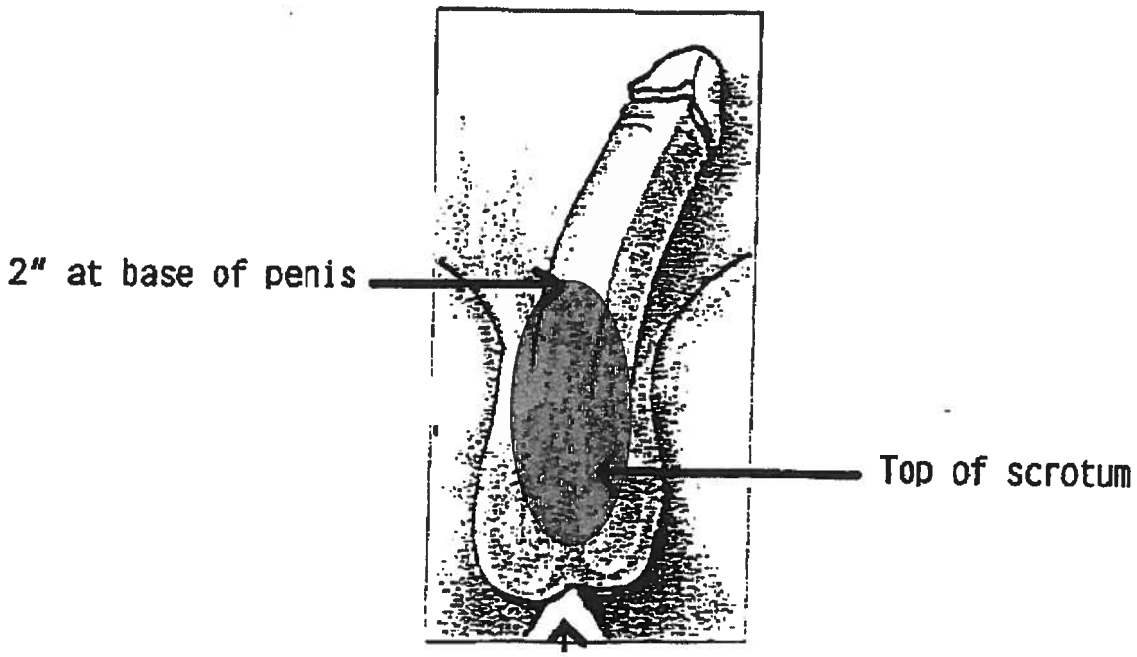
IF YOU ARE TAKING ANY OF THE FOLLOWING PRESCRIPTION MEDICATIONS PLEASE CHECK WITH THE PRESCRIBING PHYSICIAN WHEN TO DISCONTINUE THEIR USE PRIOR TO PROCEDURE/SURGERY.

COUMADIN	PLAVIX	TICLID

Your cooperation can help avoid bleeding complications following your procedure.

SHAVING / CLIPPING INSTRUCTIONS FOR THE DAY OF VASECTOMY

On the day of the procedure you should shave or preferably clip the hair at the bottom 2 inches of the penis and the top/front of the scrotum.



PLEASE CLIP OR SHAVE ON THE **DAY OF** THE PROCEDURE, **NOT THE NIGHT BEFORE.**

ALSO, PLEASE REMEMBER TO **WEAR** AN ATHLETIC SUPPORTER OR TIGHT BRIEFS **WHEN YOU COME** FOR YOUR PROCEDURE.

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.