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.

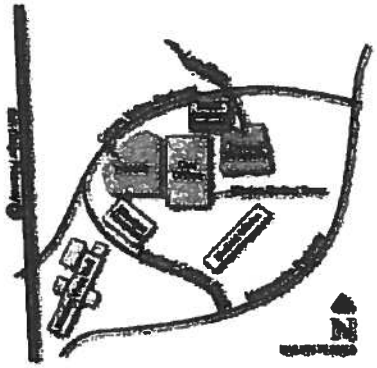
For your convenience, I have 2 office locations. My Mission Viejo office is located at 26732 Crown Valley Parkway (in the Mission Medical Tower) in Suite #327. Paid parking is available in the covered parking structure. Our office can be reached by turning at Los Altos off of Crown Valley Parkway. (See 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
IPSI- A Medical Corporation
26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
Phone 949-364-4400

PATIENT VASECTOMY REVERSAL QUESTIONNAIRE

Patient Name: _____

Date: _____

Referred by: _____

Are you seeking care to have a vasectomy reversed: Yes No

Any associated complaint:

_____

Please describe the reason that you are seeking to conceive now:

_____

_____

Your age: years old

This section for doctor use only

_____

_____

_____

_____

_____

_____

VASECTOMY HISTORY (Begin Here)

When did you undergo your vasectomy? _____

Was there any problem during or after your vasectomy? Yes No

If yes, please describe:

_____

_____

_____

Do you recall your doctor using clips to perform your vasectomy? Yes No

Did you have a semen analysis after your Vasectomy, that showed the absence of sperm? Yes No

When was your partner's most recent gynecological exam? _____

Has your partner been told that she should be able to conceive? Yes No

Has your partner been told that she has a condition that might prevent her from conceiving? Yes No

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

Have you ever been injured in the scrotal area Yes No

If so, please describe_____

_____

Patient Name: _____

Have you ever had an inguinal hernia repair Yes No

Have you had prostatitis (inflamation of the prostate) before? Yes No

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

_____

_____

Are you having sexual problems? Yes No

If so, please describe:

_____

_____

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

_____

_____

Did you look on the Internet for information on vasectomy reversal? Yes No

What main Internet search engine do you use?

_____

Please mark here ☐ if you have not had an opportunity to review the Vasectomy.Com website before your visit.

Your Past Medical & Surgical History:

Illnesses – please circle all that apply and list others:

High blood pressure	Diabetes	Bleeding problems	Kidney problems
Heart disease	Arthritis	Liver disease/hepatitis	Stomach ulcers/reflux
Heart arrhythmia	Osteoporosis	Glaucoma	Thyroid problem
Cancer type_____	Stroke	Heart murmur	Venereal diseases

Other_____

Other hospitalizations_____

Do you use antibiotics for prevention for dental or medical procedures? No Yes _____

Operations – list any operations you have had and the year of the procedure

_____

_____

_____

_____

Fractures & Injuries – list any fractures or serious accidents you have had:

_____

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

_____

_____

_____

_____

_____

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

_____ _____

_____ _____

_____ _____

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

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

Patient Name:

Social History – please circle or fill in the blank

Tobacco use: Never Presently Past (year quit _____) ____ packs a day for ____ years

Alcohol use: None Occasional Regular _____

Your occupation: _____

Marital status: Single Married Divorced Widowed Religious reference (optional)_____

Your partner's name: _____ Partner's occupation_____

How long have you been together with your present partner? ____ years

Number of **your** previous children by any previous marriage? _____

Number of **your partner's** children by any previous marriage? _____

Complete Review of Systems

Circle any current or recent problems with the following:

CONSTITUTIONAL
- Any recent weight change Y N
- Fever or chills Y N
- Headache Y N

CARDIOVASCULAR
- Chest pain or angina Y N
- Swelling of legs Y N
- Varicose veins Y N
- Other _____

HEMATOLOGIC/LYMPHATIC
- Easy bruising or bleeding Y N
- Anemia Y N
- Swollen glands Y N
- Other _____

MUSCULOSKELETAL
- Joint pain Y N
- Back pain Y N
- Neck pain Y N
- Other _____

NEUROLOGIC
- Numbness/tingling Y N
- Tremors Y N
- Seizures Y N
- Dizziness Y N
- Other _____

INTEGUMENTARY(SKIN)
- Skin rash Y N
- Itching Y N
- Other _____

RESPIRATORY
- Cough Y N
- Wheezing Y N
- Shortness of breath Y N
- Other _____

GASTROINTESTINAL
- Abdominal pain Y N
- Nausea or vomiting Y N
- Blood in stool Y N
- Black stool Y N
- Recent change in stool Y N
- Heartburn/indigestion Y N
- Hemorrhoids Y N
- Other _____

GENITOURINARY
- Leaking urine Y N
- Frequent urinary infections Y N
- Urinary retention Y N
- Other _____