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.

ADVANCED CENTER FOR PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

Patient:_____ **Date:**_____ **Page 1**

FEMALE 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
Fibromyalgia
Gastroesophageal Reflux Disease
Glaucoma
Heart Disease
Hepatitis
Hyperparathryoidism
Hypothryoidism
Lumbar Disc Disorders
Multiple Sclerosis
Myocardial Infarction (MI)
Parkinson's Disease
Renal Stones
Rheumatic Fever
Spinal Cord Injury
Other medical problem(s), Type:

_____

SURGICAL HISTORY

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

Abdominal Hysterectomy
Abdominal Surgery, Type:

_____
Appendectomy
Back Surgery
Bladder Suspension
CABG X_____vessels
Cervical Conization/LEEP
Cystocele (urinary bladder) Repair
Dilation/Curettage
Cholecystectomy (removal of the gall bladder)
Endometrial Ablation
Facial Surgery, Type:

_____
Hip Surgery
Knee Surgery
Laparoscopy
Labial Surgery
Mastectomy on _____side
Vaginal Surgery
Sling Procedure
Tonsillectomy
Unilateral/Bilateral Salpingo-oophorectomy (removal of ovaries)
Vaginal Hysterectomy
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

_____
_____
_____

FAMILY HISTORY Please indicate illnesses these family members have had:

Maternal (Mother) Side:_____ Son:_____

Paternal (Father) Side:_____ Sister:_____

Daughter:_____ 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

HEALTH MAINTENANCE

	Colonoscopy	Bone Density	Health Screen Lab Tests	Pap Smear	Mammogram
Month and Year of Last:	_____	_____	_____	_____	_____

Menstrual History:

Last Menstrual Period (LMP):_____
Normal Menses Yes No
Severity of Menstruation Light Normal Heavy
Menopause Yes No

Birth Control Method
Natural Barrier Implant
IUD Vaginal Ring Injectable
Tubal Ligation Oral Contraceptive
Vasectomy

Pregnancy History:

Number of Pregnancies: _____
Number of Vaginal Deliveries: _____
Number of C-Section Deliveries: _____

Largest Birth Weight: _____pounds
[ ] delivered with forceps
[ ] delivered by vacuum

REVIEW OF SYSTEMS: Please **circle** all symptoms that you **currently** have:

Constitutional
Chills
Fever
Weight Gain

Eyes
Blurred Vision
Double Vision

Earn/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
Pain with intercourse (dyspareunia)
Vaginal Dryness

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

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

Kym A. Kanaly, M.D., Patricia A. Wallace, M.D., Annelise Merriner, PA-C

Patient Name: _____ Date: _____

Reason for visit today: (Please check for **one** of the below listed reasons)

☐ **Annual GYN exam *without* GYN issues:**

☐ **Annual GYN exam *with* GYN issues:**
Please check appropriate issue(s) below. These issues may be addressed at a separate visit from your annual exam. Your insurance may allocate a co-payment for the gyn portion of your visit when combined with an annual exam.

☐ **GYN issues without an annual exam:**
Please check appropriate issue(s) from the list below.

If you have specific GYN issues you would like addressed, please check all issues that apply to you.

Menstrual Irregularities
__Heavy periods __Bleeding between periods __lack of periods __painful period
__fibroids __premenstrual syndrome

Perimenopausal/Menopausal Symptoms
__hot flashes __night sweats __insomnia __mood changes __vaginal dryness
__hormone replacement therapy discussion

Sexual Complaints
__decreased libido __problems with orgasm __pain with sexual activity __vaginal dryness

Vaginal Complaints
__increased vaginal discharge __vaginal itching __vaginal pain __vaginal dryness __vaginal mass/lump

Vulvar Complaints
__Vulvar mass/lump __vulvar sore __vulvar pain

Pelvic Pain
__pelvic pain __ovarian cyst __abdominal bloating

Urinary Complaints
__burning with urination __increased urinary frequency __increased urinary urgency __blood in urine
__urinary incontinence (leaking)

Breast Complaints
__breast mass __breast pain __nipple discharge __breast skin changes

Other
__abnormal PAP __birth control __sexually transmitted disease

Other GYN-related issue(s), not listed above:

_____

_____

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** _____

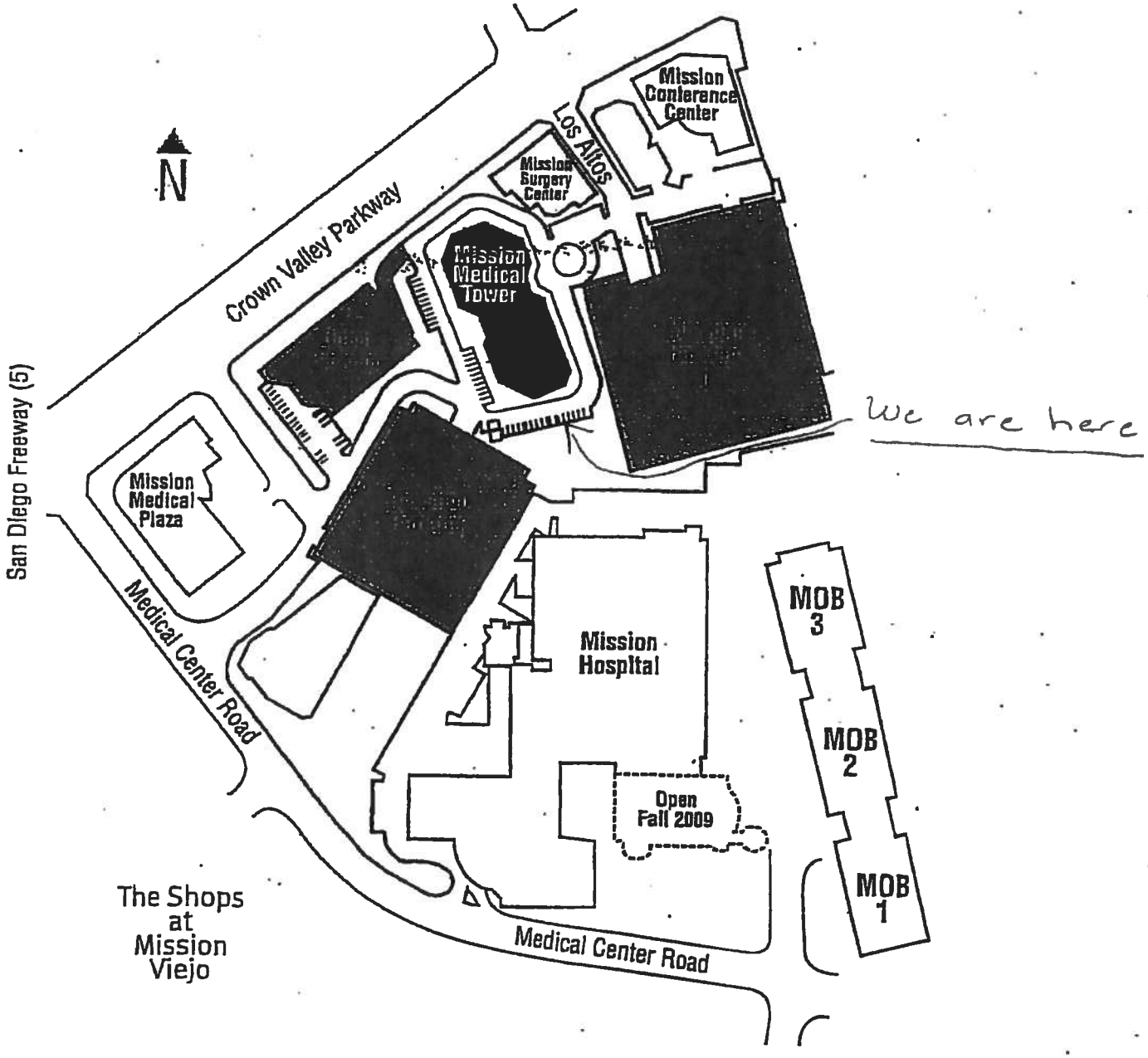
Signature _____ **Date** _____

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

Kym A. Kanaly, M.D. Patricia A. Wallace, M.D.
26732 Crown Valley Parkway, Suite 327 Mission Viejo Ca 92691 949.364.4400

Patient Name: **Date:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Annual Well Woman Exam** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Annual Well Woman Exam** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Full, Annual Well Woman Examination, including a pelvic exam and pap smear collection.	Medicare does not pay for all of your health care costs. Your Medicare benefits do not pay for this service more often than every two years.	$100.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Annual Well Woman Exam** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Annual Well Woman Exam** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Annual Well Woman Exam** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. Annual Well Woman Exam** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: The fact that Medicare does not pay for a particular service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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.