Urogynecology
OF KANSAS CITY

CONTACT INFORMATION
MAIN OFFICE | 10707 W 87th ST | Overland Park, KS 66214 | **P 913.262.3000** | F 913.262.3002
SATELLITE OFFICE | ENCOMPASS BLDG I 4811 S ARROWHEAD DR I INDEPENDENCE, MO 64055 I **P 913.262.3000** I F 913.262.3002

Thank you for choosing Urogynecology of Kansas City for your medical care. We are dedicated to providing women with superior individualized care for pelvic floor disorders. We take time to help you understand your condition and we develop a treatment plan that puts your goals first. In order to expedite your care, we ask that you bring the following items to your first visit.

- Insurance card & co-pay
- Drivers License
- Completed forms – If you arrive without your completed paperwork we may have to reschedule your appointment.

We look forward to meeting you at your scheduled appointment. We respect your time and run our office on schedule. To do this, **we do not double book appointments**. If you are unable to make your appointment, kindly provide **48 hours** notice to avoid a cancellation fee. The fee is equal to the visit type that you have scheduled, which can range from **$100-$250**.

Sincerely,

Patrick A. Nosti, MD FACOG, FPMRS

Fellowship Trained & Board Certified

Urogynecology
OF KANSAS CITY

Patient Name:_____**DOB**_____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature _____ Date _____

I authorized this facility to release information to (Please check all that apply):

☐SPOUSE (name & phone number) _____

☐CHILDREN: (name & phone number) _____

☐OTHER: (name & phone number) _____

☐No One

☐MESSAGES MAY BE LEFT AT THE FOLLOWING LOCATIONS (Check those that apply) ☐Home ☐ Cell ☐ Work

Signature _____ Date _____

Medicare Patients

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer_____any information needed to determine those benefits payable for related services.

Signature _____ Date _____

MEDICARE LIFETIME AUTHORIZATION

HIC#_____

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signature_____ Date _____

Print Name:_____ Title or Relationship: _____

Witnessed by: _____ Address: _____

If signed by other than beneficiary, state reason the patient was unable to sign: _____

Urogynecology

OF KANSAS CITY

Patent Registration Form

PATIENT INFORMATION

Patient's Name (Last) ____________________ (First) _____________________ (MI) _________ Previous Name _____________________
Street Address ____
City, State ____ Zip ______________
Home Phone _________________________ Cell No. ___________________________ Work Phone ______________________ Ext. _____
E-mail address ____
Primary Care Provider ____ Referring Provider ___________________________________
Date of Birth MM ______/DD______/YYYY______

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partnered

Social Security Number __________ -__________ -__________ Employer Name ____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military

Student Status ☐ Full-Time Student ☐ Part-Time Student ☐ Not a Student

Emergency Contact: Last Name ____ First Name ________________________________

Phone number ____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____ ☐ Guardian

Street Address ____
City, State ____ Zip ______________
Home Phone _________________________ Cell No. ___________________________ Work Phone ______________________ Ext. _____

**************************************RESPONSIBLE PARTY INFORMATION**

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self
Responsible Party Name (Last) _______________ (First) __________________ (MI) _________ Previous Name _____________________
Guarantor Account Number ____ Date of Birth MM ______/DD______/YYYY______
Social Security Number __________ -__________ -__________ Telephone _________________________________
E-mail address ____
Street Address ____
City, State ____ Zip ______________
Employer ____ Employer Phone Number ____________________________________

**************************************PRIMARY INSURANCE INFORMATION***

Insurance Company/Phone Number ____ (______)_________________________
Name of Insured ____ Patient's Relationship to Insured _______________________
Subscriber ID (Policy Number) _______________________ Group ID __________________________ Copay Amount _________________
Effective Date ____________________ Termination Date ________________________ Date of Birth MM ______/DD______/YYYY______

*************************************SECONDARY INSURANCE INFORMATION***

Insurance Company/Phone Number ____ (______)_________________________
Name of Insured ____ Patient's Relationship to Insured _______________________
Subscriber ID (Policy Number) _______________________ Group ID __________________________ Copay Amount _________________
Effective Date ____________________ Termination Date ________________________ Date of Birth MM ______/DD______/YYYY______

***PHARMACY**

Name _________________________________ Phone __________________________ Fax _______________________________________
Street Address ____
City, State ____ Zip __________________________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.
Patient (or Responsible Party) Signature ____ Date ____________________________________

Patient Name:_____**DOB**_____

PRIVACY NOTICE
FOR
UROGYNECOLOGY OF KANSAS CITY, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations.

You may revoke this consent at any time by notifying our office in writing, except to the extent our office has taken action on your consent.

Please refer to the "Privacy Notice" posted on our website or provided upon request for a full description of the uses and disclosures of your protected health information. You have the right to review the "Privacy Notice" prior to signing this consent.

Our office has reserved the right to change its privacy practices describe in the "Privacy Notice". You may request a current copy of the "Privacy Notice" in writing or in person.

You have the right to request our office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations. However, our office is not required to agree to such restrictions.

I hereby consent to the use and disclosure of my protected health information by Urogynecology of Kansas City, LLC, its staff and its business associates for purposes of treatment, payment, and health care options.

_____
Signature

_____
Signature of Personal Representative of Patient

_____
Description of Representative's Authority to Act for the Patient

Date:_____

Urogynecology
OF KANSAS CITY

Patient Name_____**DOB**_____
Primary Care Physician _____ **Referring Physician** (*if different than PCP*) _____
If self referred how did you hear about our practice? _____

In order to help us provide you with the best medical care, please complete this form in as much detail as possible. Please bring the completed form with you at the time of your first visit. DO NOT MAIL IT.
Please write, in your own words, the nature of your current gynecologic, colorectal or urologic medical problem:

_____

_____

BLADDER Symptoms

Do you leak urine? (if yes, complete below) Yes ☐ No ☐
For how long? _____
Do you have urine leakage with **coughing, laughing or physical activity**? Yes ☐ No ☐
Do you have urine leakage with **urgency** or on the way to the bathroom? Yes ☐ No ☐
Do you leak urine while **asleep**? Yes ☐ No ☐
Do you use **pads** for urine leakage? Yes ☐ No ☐
If yes, what type of pad? _____ How often do you change your pad per day?_____
On average, how often do you urinate during the **day**? ____ times
On average, how often do you wake at **night** to urinate? ____times
Do you often have a strong **urge** to urinate? Yes ☐ No ☐
Do you have **difficulty urinating** or do you strain with urination? Yes ☐ No ☐
Do you feel that your bladder **does not empty** completely? Yes ☐ No ☐
Do you experience a **burning sensation** when you urinate? Yes ☐ No ☐
Do you have **blood** in your urine? Yes ☐ No ☐
Do you have **more than 3** bladder infections per year? Yes ☐ No ☐
Have you ever been **treated** for urinary symptoms with medicine or surgery? Yes ☐ No ☐
Fluid intake (total per day)
Coffee _____ oz Caffeinated ____ Decaffeinated ____
Tea _____ oz Caffeinated ____ Decaffeinated ____
Soda _____ oz Caffeinated ____ Decaffeinated ____
Water _____ oz
Other _____ oz
Total fluid intake/day _____ oz

VAGINAL PROLAPSE Symptoms

Do you experience pelvic **pressure, heaviness or dullness**? Yes ☐ No ☐
Do you see or feel a **bulge**, or something falling out in the vaginal area? Yes ☐ No ☐
Do you have to manually replace or push on the vagina to assist with **urination** or **bowel movements**? Yes ☐ No ☐
Have you ever had a **pessary** or **surgery** for prolapse? Yes ☐ No ☐

SEXUAL Symptoms

Do you have sexual relations with a partner? Yes ☐ No ☐
If yes, how long have you been with your current sexual partner? _____
Is/are your partner(s) Male ☐ Female ☐ Both ☐
Do you have pain with intercourse? Yes ☐ No ☐
Is your sex life satisfactory to you? Yes ☐ No ☐
Have you been a victim of domestic violence or sexual abuse? Yes ☐ No ☐

Patient Name:_____**DOB**_____

BOWEL Symptoms

Do you have problems with: Diarrhea? Yes ☐ No ☐

Constipation? Yes ☐ No ☐

Fecal incontinence/leaking stool? Yes ☐ No ☐

If yes, for how long? _____

Do you leak… solid stool? ☐ loose/liquid stool? ☐ gas? ☐

Do you leak stool with **coughing, laughing or physical activity**? ☐ with **urgency**? ☐

Anal/rectal **bleeding**? Yes ☐ No ☐

Anal pain or **hemorrhoids**? Yes ☐ No ☐

Change in bowel habits? Yes ☐ No ☐

Do you feel that your bowels **do not empty completely** after a bowel movement? Yes ☐ No ☐

Do you have to **push on the vagina** or around the rectum to empty your bowels? Yes ☐ No ☐

Frequency of bowel movements _____/day;_____/week

Have you had a colonoscopy? Yes ☐ No ☐

Date of last___/___/___ Normal: Yes ☐ No ☐

PAST MEDICAL HISTORY: (Check all that apply)

☐ High blood pressure	☐ Emphysema	☐ Rheumatoid arthritis	☐ Stroke	☐ Kidney stones	☐ Fibromyalgia
☐ Heart attack	☐ COPD	☐ Lupus	☐ Multiple sclerosis	☐ Kidney infection	☐ Bipolar disorder
☐ Heart failure/disease	☐ Sleep apnea	☐ Crohn disease	☐ Parkinson disease	☐ Kidney disease	☐ Depression
☐ Atrial fibrillation	☐ Pneumonia	☐ Ulcerative colitis	☐ Spine problems	☐ Glaucoma	☐ Anxiety
☐ Blood clot	☐ Thyroid disease	☐ Ulcer	☐ Neurologic disease	☐ Cancer, type: _____	☐ Seizures
☐ Bleeding problems	☐ Liver disease	☐ Irritable bowel syndrome	☐ Memory loss		

☐ Other medical problem(s): _____

SURGICAL HISTORY: (Check all that apply) Have you had any operations? If so, in what **year**? Yes ☐ No ☐

☐_____ Hysterectomy	☐ _____ Hernia repair (mesh? Y/N)	☐ _____ Hip surgery	☐ _____ Gastric bypass
☐ _____ Ovary removal (both/L/R)	☐ _____ Exploratory laparotomy	☐ _____ Knee surgery	☐ _____ Tubal ligation
☐ _____ Appendectomy	☐ _____ Diagnostic laparoscopy	☐ _____ Spine surgery	☐ _____ Endometriosis
☐ _____ Gallbladder	☐ _____ Bowel resection	☐ _____ Breast surgery	
☐ _____ C-section	☐ _____ Cancer surgery, type: _____	☐ _____ Thyroid surgery	

☐ Other surgeries: _____

Have you had a hysterectomy? Yes ☐ No ☐

If yes, year and reason: _____

Route of surgery: ☐ Abdominal (open) ☐ Vaginal ☐ Laparoscopic ☐ Robotic

Were ovaries removed? ☐ Yes, both ☐ Left only ☐ Right only ☐ Not removed

FAMILY HISTORY

Father: ☐ Alive ☐ Deceased; if so, cause_____ Health issues_____

Mother: ☐ Alive ☐ Deceased; if so, cause_____ Health issues_____

Do you have a family history of cancer of the: ☐ ovary ☐ breast ☐ uterus ☐ cervix ☐ kidney ☐ bladder

If yes, relationship and age at diagnosis: _____

Other family members with health issues? _____

_____

Patient Name:_____**DOB**_____

SOCIAL HISTORY & HEALTH HABITS

Current marital status: □ Married □ Single □ Divorced □ Widowed □ Separated □ Partnered

Number of people living in your household _____

Current or previous occupation _____ Are you retired? Yes □ No □

Do you smoke? □ No □ Yes If no, did you smoke in the past? □ No □ Yes

If current smoker, how many packs per day? _____ Do you want to quit?_____

If past smoker, how many packs per day? _____ For how many years? _____ When did you quit? _____

Do you use alcohol? Yes □ No □

If yes, how many alcoholic beverages do you drink per week? _____

Do you use drugs? Yes □ No □

Do you exercise regularly? Yes □ No □

If yes, what type of exercise do you do? _____

GYNECOLOGIC HISTORY:

Age when periods first started _____

Have you gone through menopause? Yes □ No □

If yes, at what age? _____

If postmenopausal, do you have any vaginal bleeding? Yes □ No □

Are you taking estrogen replacement therapy? Yes □ No □

If yes, which type? □ Oral □ Vaginal □ Other_____

If you have not gone through menopause:

Are your periods regular? Yes □ No □

Number of days from the **start** of one period to the **start** of the next period _____

How **long** do your periods last? _____

Do you have bleeding **between** periods? Yes □ No □

Do you have **heavy** menstrual periods? Yes □ No □

Do you have **pain** with periods? Yes □ No □

First day of last menstrual period __/__/___

Birth control method _____

Date of last Pap smear: ___/___/___ Normal: Yes □ No □

Have you ever had an abnormal pap smear? Yes □ No □

Have you ever had treatment to your cervix for an abnormal pap (biopsy, cryotherapy, LEEP, cone, etc.) Yes □ No □

Date of last mammogram: ___/___/___ Normal: Yes □ No □

Have you ever had a sexually transmitted infection? Yes □ No □ If yes when? _____

□ Herpes □ Chlamydia □ Gonorrhea □ Trichomonas □ HIV □ Warts/condyloma

□ Pelvic inflammatory disease/PID □ Other _____

PAST OBSTETRICAL HISTORY:

Number of pregnancies _____

Number of children currently living _____

Number of miscarriages _____

Number of abortions _____

Number of ectopic (tubal) _____

Type of deliveries (number of each)

Vaginal _____

Cesarean (c-Section) _____

Forceps/Vacuum _____

Weight of largest vaginal delivery pounds _____ ounces _____

Tear into the rectum? Yes □ No □

Patient Name:_____**DOB**_____

ALLERGIES:

Do you have any allergies to medications Yes □ No □

If yes, please list (including reaction to each medication):_____

_____

MEDICATIONS Pleasl list all medicines which you are currently taking (including contraceptives, hormones, vitamins and over the counter medications.) Use a separate sheet if necessary.

1. MEDICATION:_____ DOSAGE:_____
2. MEDICATION:_____ DOSAGE:_____
3. MEDICATION:_____ DOSAGE:_____
4. MEDICATION:_____ DOSAGE:_____
5. MEDICATION:_____ DOSAGE:_____
6. MEDICATION:_____ DOSAGE:_____
7. MEDICATION:_____ DOSAGE:_____
8. MEDICATION:_____ DOSAGE:_____
9. MEDICATION:_____ DOSAGE:_____
10. MEDICATION:_____ DOSAGE:_____
11. MEDICATION:_____ DOSAGE:_____
12. MEDICATION:_____ DOSAGE:_____
13. MEDICATION:_____ DOSAGE:_____
14. MEDICATION:_____ DOSAGE:_____
15. MEDICATION:_____ DOSAGE:_____
16. MEDICATION:_____ DOSAGE:_____
17. MEDICATION:_____ DOSAGE:_____

Patient Name:_____**DOB**_____

Review of symptoms: Please check if any of the following symptoms apply:

General/Constitutional
□ Change in appetite
□ Chills
□ Fever
□ Weight gain
□ Weight loss
□ Other _____

Respiratory
□ Cough
□ Spitting up blood
□ Shortness of breath
□ Wheezing
□ Other _____

Genitourinary
□ Vaginal discharge
□ Kidney stone
□ Other _____

Allergy/Immunology
□ Hives
□ Hay fever
□ Other _____

Breast
□ Breast lump
□ Breast pain
□ Nipple discharge
□ Other _____

Musculoskeletal
□ Neck pain
□ Back pain
□ Difficulty walking
□ Painful joints
□ Other _____

Ophthalmologic
□ Blurred vision
□ Dry eyes
□ Pain
□ Other _____

Cardiovascular
□ Chest pain at rest
□ Chest pain with exertion
□ Palpitations
□ Weight gain
□ Other _____

Skin
□ Itching
□ Mole (s)
□ Rash
□ Other _____

ENT
□ Decreased hearing
□ Ear pain
□ Nosebleed
□ Ringing in ears
□ Sore throat
□ Other _____

Gastrointestinal
□ Abdominal pain
□ Heartburn
□ Nausea
□ Vomiting
□ Other _____

Neurologic
□ Fainting
□ Headache
□ Loss of strength
□ Seizures
□ Tingling/Numbness
□ Tremor
□ Other _____

Endocrine
□ Cold intolerance
□ Excessive thirst
□ Heat intolerance
□ Weakness
□ Other _____

Hematology
□ Anemia
□ Easy bruising
□ Prolonged bleeding
□ Swollen glands
□ Other _____

Psychiatric
□ Psychiatric treatment
□ Anxiety
□ Depressed mood
□ Other _____

BLADDER DIARY

- You may start the diary any day of the week, but please use it for 2 days in a row.
- Record the amount of fluid you drink each hour of the day in ounces or milliliters and the type of fluid (example coffee, tea, soda, etc.)
- Record each time you urinate by placing an X in the Toilet column next to the corresponding time.
- Record each time you accidentally lose urine, even if only a small amount, by placing an X in the Accident column next to the corresponding time each day.
- If needed, you can place more than one X in each box.
- For each day, write in the time when you get up, the time you go to bed and the number of pads you used at the bottom of the column.

	Day 1 Date ___/___/____			**Day 2** Date ___/___/____		
TIME	Fluid intake	Toilet	Accident	Fluid intake	Toilet	Accident
12-12:59 am						
1-1:59 am						
2-2:59 am						
3-3:59 am						
4-4:59 am						
5-5:59 am						
6-6:59 am						
7-7:59 am						
8-8:59 am						
9-9:59 am						
10-10:59 am						
11-11:59 am						
12-12:59 pm						
1-1:59 pm						
2-2:59 pm						
3-3:59 pm						
4-4:59 pm						
5-5:59 pm						
6-6:59 pm						
7-7:59 pm						
8-8:59 pm						
9-9:59 pm						
10-10:59 pm						
11-11:59 pm						
# Pads used						
Time woke up						
Time went to bed						

CONSENT FOR PELVIC EXAM, CATHETERIZATION, AND RECTAL EXAM

Patient Name:_____

Date of Birth:_____

- **CONSENT:** I, the above patient or as the legally authorized person for the patient, hereby consent to receiving a pelvic examination, catheterization, and/or rectal examination if deemed appropriate, to be performed by my healthcare practitioner or any medical staff under the supervision of my healthcare provider.

- **NATURE OF EXAMINATIONS:** For the purpose of this consent form, a "pelvic and rectal examination" means a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes ovaries, external pelvic tissue, or rectum using a combination of modalities, which may include the provider's gloved hand and/or speculum. For the purpose of this consent form, a "catheterization during an exam" means a small catheter may be placed in the urethra to obtain a sterile specimen to provide diagnostic information related to your bladder function.

- **VALIDITY OF CONSENT:** The patient, or the patient's legally authorized person, acknowledges that this consent will remain valid from the date the patient, or the patient's legally authorized person, dates this consent form below, unless otherwise revoked.

- **REVOKING CONSENT:** The patient can revoke consent of any or all examinations at anytime. If at any point during your appointment you wish to revoke consent, notify your healthcare practitioner or other medical staff immediately.

I consent to receive a pelvic exam, rectal exam, and/or catheterization as described above.

Patient's or Guardian Signature:_____ Date: _____