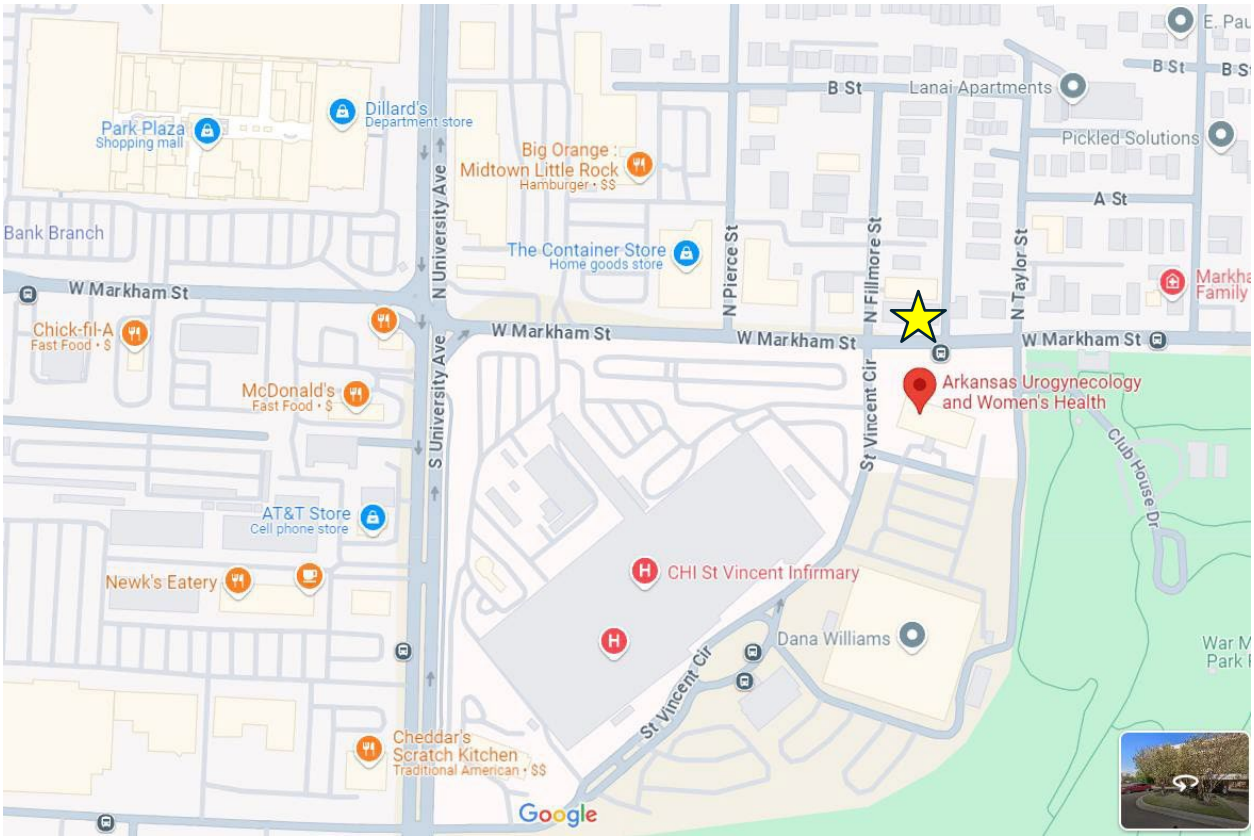
Dear _____,

We look forward to seeing you for your upcoming appointment at Arkansas Urogynecology and Women's Health.

APPOINTMENT:_____at _____with _____.

Please **arrive 30 minutes** early remember to bring:

- ✓ Insurance Card(s) and Photo ID
- ✓ Completed Paperwork
- ✓ Any relevant medical records or operative reports




Arkansas Urogynecology & WOMEN'S HEALTH

5 St Vincent Circle, Suite
300 Blandford Building
Little Rock, AR 72205
501-480-8800

**Patient Information: PLEASE ENTER NAME EXACTLY AS IT APPEARS ON DRIVER'S LICENSE**

| First Name | | Middle Name | | Last Name | |
|---|---|---|---|---|---|
| Mailing Address | | Apt # | City | State | Zip Code |
| Home Phone # | Cell Phone # | Email Address | | Date of Birth | SSN |
| Sex<br>M F | Marital Status<br>M S D W | Spouse's Name | | Spouse's Phone # | New Patient?<br>Yes or No |

| Primary Care Physician/Provider | Referring Physician/Provider |
|---|---|
| Pharmacy Name | Pharmacy Location |

| | Relationship to Patient | Contact Phone # |
|---|---|---|
| Emergency Contact | | |
| Name of closest relative not living with you | | |

| Patient's Employer | Patient's Work Phone #/Ext # |
|---|---|

| Patient's Race (please choose one) | | | | |
|---|---|---|---|---|
| □ American Native/First Nations or Alaska Native | □ Native Hawaiian/Other Pacific Islander | □ White/Caucasian | □ Asian | □ Black or African American |
| □ Hispanic | □ Unknown | □ Decline to answer | | |

| Patient's Ethnicity | | | | Language |
|---|---|---|---|---|
| □ Hispanic/Latino(a) | □ Non-Hispanic/Non-Latino(a) | □ Unknown | □ Decline to answer | |

**If Patient is a Minor or Student**

| Guardian's First Name | | Middle Name | | Last Name | |
|---|---|---|---|---|---|
| Mailing Address | | Apt # | City | State | Zip Code |
| Date of Birth | SSN | Home Phone # | Guardian's Employer | | Work Phone # |

**Insurance Information**

| Primary Insurance Company | Policy Holder's Name, DOB, & SSN | |
|---|---|---|
| Patient's Relationship to Policy Holder | ID Number | Group Number |
| Secondary Insurance Company | Policy Holder's Name, DOB, & SSN | |
| Patient's Relationship to Policy Holder | ID Number | Group Number |

Authorization and Consent: I hereby authorize Arkansas Urogynecology and Women's Health (AUWH) to furnish information to insurance carriers concerning treatment provided by AUWH, and I hereby irrevocably assign to AUWH all payments for medical services rendered. I consent to the use or disclosure of my protected health information by Arkansas Urogynecology and Women's Health for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of AUWH. I have the right to revoke this consent in writing at any time, except to the extent that Arkansas Urogynecology and Women's Health has taken action in reliance of this consent. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient or Guardian _____ Date _____

*Patient Demographics*

----------Do not write below this line----------

Arkansas Urogynecology and Women's Health New Patient Information

**GENERAL INFORMATION** Today's Date:_____

Patient Name (Print):_____DOB:_____

Preferred Name:_____

Preferred language: _____ Do you need a translator? YES or NO

Referring Physician:_____

Why are you being seen today?

_____

**Urogynecology Symptoms** (check yes or no)

| **Problems** | **Yes** | **No** |
|---|---|---|
| Do you leak urine with coughing, sneezing, laughing, or other activity? | | |
| Do you leak urine trying to get to the bathroom in time? | | |
| Do you feel like you urinate too frequently? | | |
| Do you wake up at night to urinate? | | |
| Is it hard to empty your bladder? | | |
| Is constipation a common problem for you? | | |
| Do you lose bowel movements or gas by accident? | | |
| Is there pressure in your bottom or a bulge of your female organs? | | |
| Do you have a lot of bladder or urinary tract infections? | | |

**Other Urogynecology Symptoms or Concerns:**

_____

_____

Marital Status (circle one): Single Married Divorced Widowed

Are you sexually active? YES or NO

How many sexual partners do you currently have?_____How many in last 6 months?____

My sexual partners are: Male Female Both

Do you have pain with sex? YES or NO



----------Do not write below this line----------

## Medication List

If you have a copy of your medication list, please give to the front desk to scan and you do not have to fill out the medication section.

Please list all current medications, dosages, and how you take them. Include prescriptions AND any over the counter medications, vitamins, and supplements you take as well.

| Medication | Dosage | How many times per day | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Allergies

Please list all allergies you have to medications and/or substances (in particular seafood, iodine, contrast dye, latex) and the type of reaction it causes.

□ I do not have any known drug allergies

| Medication/Substance | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**General Review of Systems** (check all that apply to you recently)

| Constitutional | Gastrointestinal | Genital/Urinary |
|---|---|---|
| ☐ Change in energy/activity level<br>☐ Change in appetite<br>☐ Chills<br>☐ Fever<br>☐ Sweats<br>☐ Fatigue<br>☐ Unexpected weight change<br><br>Heart/Lungs<br>☐ Chest pain<br>☐ Shortness of breath/trouble breathing<br><br>Neurologic<br>☐ Headache<br>☐ Dizziness/ lightheadedness<br>☐ Fatigue | ☐ Bloating<br>☐ Stomach pain<br>☐ Rectal/anal bleeding<br>☐ Rectal/anal pain<br>☐ Blood in stool<br>☐ Constipation<br>☐ Diarrhea<br>☐ Nausea<br>☐ Vomiting<br><br>Endocrine<br>☐ Uncontrolled thirst<br>☐ Uncontrolled hunger<br>☐ Feeling cold<br>☐ Feeling hot<br><br>Musculoskeletal<br>☐ Body aches<br>☐ Joint pain | ☐ Difficulty urinating<br>☐ Pain with urinating<br>☐ Pain with sexual intercourse<br>☐ Blood in urine<br>☐ Genital sores<br>☐ Menstrual problem<br>☐ Pelvic pain<br>☐ Vaginal bleeding<br>☐ Vaginal discharge<br>☐ Vaginal pain<br>☐ Back pain<br>☐ Less frequent urinating<br>☐ More frequent urinating<br><br>Please list any other symptoms you are having:_____<br>_____ |

**Surgical History**

| | | |
|---|---|---|
| ☐ Appendix removed | ☐ Gallbladder removed | ☐ Hernia repair |
| ☐ Heart surgery | ☐ Ovary removed | ☐ Tubal ligation |
| ☐ Hysterectomy | ☐ Bladder surgery | ☐ Prolapse surgery |

List any other surgeries you have had, including dates of surgery:

_____

_____

_____

_____

**Hospitalization History** Have you been hospitalized in the last 6 months? YES or NO

Reason: _____

Please list any other reasons or times you have been hospitalized:

_____

_____

**Gynecologic and Obstetric (OBGYN) History**

| |
|---|
| # of Pregnancies:_____# of Vaginal Deliveries:_____# of C-Section Deliveries:_____<br># of Miscarriages:_____# of Abortions:_____# of Living Children:_____<br># of Deliveries Using Forceps/Vacuum:_____Weight of largest baby born vaginally:<br>Did you tear into the rectum during delivery? YES or NO<br>Any other delivery or pregnancy complications?_____ |
| Date of last menstrual period (if applicable):_____<br>Age of onset of menopause (if applicable):_____<br>When was your last pap smear?_____Was it normal? YES or NO<br>When was your last mammogram? _____Was it normal? YES or NO<br>When was your last colonoscopy? _____Was it normal? YES or NO |
| Please circle any past birth control methods you have tried:<br>Condoms Birth control pills Patch NuvaRing Depo Shot Nexplanon<br>Paraguard/Copper IUD Hormonal IUD (Mirena, Kyleena, Skyla, Liletta) Other |
| Please circle any that you have had:<br>Herpes HPV Genital warts Chlamydia Gonorrhea HIV Hepatitis<br>Syphilis Trichomoniasis/Trich Pelvic Inflammatory Disease |

**Past Medical History** (please check all that apply to you, past or present)

**Heart**
- ☐ High blood pressure
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Congestive heart failure
- ☐ Heart murmur/arrhythmia
- ☐ Stroke
- ☐ Cardiac stent
- ☐ Other:_____

**Blood**
- ☐ Anemia
- ☐ Hemophilia
- ☐ Blood clot (PE/DVT)
- ☐ Other:_____

**Infectious Disease**
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Other:_____

**Cancer**
- ☐ Type:_____

**Lungs**
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Other:_____

**Musculoskeletal**
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Other:_____

**Infectious Disease**
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Other:_____

**Kidney/Bladder**
- ☐ Kidney stones
- ☐ Interstitial cystitis
- ☐ Other:_____

**Gastrointestinal**
- ☐ GERD/Acid reflux
- ☐ IBS (irritable bowel syndrome)
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Other:_____

**Neurology/Psychiatry**
- ☐ Seizures
- ☐ Neuropathy
- ☐ Depression/anxiety
- ☐ Other:_____

**Endocrine**
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other:_____

**Surgical**
- ☐ Anesthesia complications
- ☐ Surgical complications

Other medical problems not listed:

_____

_____

_____

_____

_____

**Family History** Have any of your immediate family members been diagnosed with:

| | |
|---|---|
| □ Heart disease | □ Breast cancer |
| □ Blood clots (DVT/PE) | □ Colon cancer |
| □ Lupus | □ Ovarian cancer |
| □ Connective tissue disorders | □ Uterine cancer |
| □ Polycystic kidney disease | □ Uterine fibroids |
| □ Bleeding disorders | □ Infertility |
| □ Difficulty with anesthesia | □ Endometriosis |

**Social History**

| **Substance** | **Current use? (Circle)** | **Past use? (Circle)** | **Amount** |
|---|---|---|---|
| Smoking/chewing tobacco/nicotine vape | YES or NO | YES or NO | # of packs per day:_____<br>How long:_____<br>Quit (year, if applicable):_____ |
| Alcohol | YES or NO | YES or NO | # of drinks per week (or day if daily use):_____ |
| Recreational Drugs | YES or NO | YES or NO | Type(s):_____<br>How often:_____ |
| Caffeine | YES or NO | YES or NO | How much:_____ |

Arkansas Urogynecology & WOMEN'S HEALTH

# Authorization for Medical Information Access

Should you require someone in your family or a friend to inquire about your appointment, lab results, billing information, plan of care, etc.., on your behalf, we must have each individual listed below that you wish to be able to receive this information. If you do not designate an individual, they will not be given any information until a request is signed authorizing that individual.

I, _____ (print patient's name), hereby consent to allow the following person(s) access to information of my account/medical record that would otherwise be considered protected health information:

☐ Mark box to designate Emergency Contact

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

_____ _____

Signature (Patient or Legal Guardian) Date

5 St Vincent Circle Ste 300 | Little Rock, AR 72205
Phone (501) 480-8800 | Fax (501) 480-8815 | www.arurogyn.com
Susan Barr, MD | Sallie Oliphant, MD | Becca Austin, APRN | Amy Wilson, APRN | Claudia Helbig, PA-C

Arkansas Urogynecology & WOMEN'S HEALTH

# Medical Consent Form

Patient Name: _____ Date of Birth: _____

Annual Consent for Services: I consent to the services that may be performed by an Arkansas Urogynecology and Womens Health (AUWH) physician or non-physician "provider". I understand I can withdraw this consent at any time. This consent and agreement will apply to any provider's services I may obtain from an AUWH provider at the provider's office, hospital, or ambulatory surgical facility.

Financial Agreement: I guarantee and agree to pay for all goods and services provided to me or the patient named above at the rates listed in Arkansas Urogynecology and Womens Health Charge Description Master as of the date of treatment, unless I am entitled to pay a different amount under my (or the patient's) health insurance plan or my (or the patient's) status as a Medicare and/or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and/or collection expenses.

Assignment of Insurance Benefits: I assign my (or the patient's) rights under all insurance and benefit plan documents and authorize direct payments to AUWH of all insurance and plan benefit payments for services provided by AUWH. By paying AUWH, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct; I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare including but not limited to the effective date of coverage. I also authorize AUWH to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Clinic Rules: I understand that my visitors and I must obey all AUWH clinic rules. I understand that if I or my visitors do not follow the rules, AUWH may pursue corrective action.

Demographic Information: I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform AUWH of any changes as soon as possible.

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Arkansas Urogynecology & WOMEN'S HEALTH

Patient Name: _____ Date of Birth: _____

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when AUWH may use or disclose information for treatment, payment, and health care operations. The NOPP is considered part of this Consent and Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from AUWH and is otherwise available upon request.

Personal Valuables: I understand that as a patient, I am encouraged to leave valuable personal items at home. If I choose not to, I understand that AUWH is not responsible for loss or damage to these items.

Independent Contractors/Providers: I understand that separate bills may be sent for ancillary services from non-AUWH providers such as pathologists and laboratories in addition to the AUWH bill.

Telephone Calls: By providing my landline, cell phone number, and/or email address, I expressly consent to receiving communications from AUWH, its staff, or its contractors, including collection agents, to any landline, cell phone number, email, or other electronic communication I provide or that you later acquire for me. AUWH may use this information to contact me live, leave a voicemail, text, email, or by pre-recorded messages regarding my account(s) and/or healthcare service(s) provided to me. AUWH may use an auto dialer to deliver messages to me. Providing you with my contact information is not a condition of receiving healthcare services.

Appointment Reminders: We may notify you by voice call, by text message (standard rates may apply), or both. Please let us know if you prefer not to receive appointment reminders by voice call and/or text messaging.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Patient/Responsible Party Signature: _____ Date: _____
If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____

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Arkansas Urogynecology & WOMEN'S HEALTH

*Revised 12/09/2024*

# Authorization For Access, Use, or Disclosure of Protect Health Information

I, _____, whose date of birth is _____hereby authorize Arkansas Urogynecology and Womens Health to use, allow access to and/or disclose my individually identifiable health information as described below for the purpose of continuity of my medical care.

I authorize the following person(s) or organization(s) to receive and/or disclose medical information:

- ☐ Primary care and specialty provider(s)
- ☐ Hospital(s) and Urgent Care Clinic(s)
- ☐ Physical therapy provider(s)

The following types of records may be received and/or disclosed for continuity of my medical care:

- ☐ Radiology studies
- ☐ Operative reports
- ☐ Laboratory and pathology results
- ☐ Hospital and Emergency Department records
- ☐ Provider clinical notes

Re-Disclosure: I understand that the information used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

Revocation: I understand that this authorization will remain in effect unless otherwise revoked by me in writing. I understand that I may revoke this authorization at any time by notifying Arkansas Urogynecology and Womens Health.

Signature of Patient or Legal Guardian: _____ Date: _____
If signed by other than patient, indicate relationship: _____

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Arkansas Urogynecology & WOMEN'S HEALTH

## No Show Policy

Arkansas Urogynecology and Womens Health is committed to the delivery of quality care in a professional, caring, and compassionate manner. To provide efficient care for all our patients, we have established the following processes:

A "No Show Appointment" is defined as any appointment which is missed without being cancelled 24 hours in advance. Our office will charge the patient $50 for a no-show office appointment.

A "No Show for Surgery" is defined as any scheduled surgery which is missed without being cancelled 48 hours in advance. Our office will charge $100 for a no-show scheduled surgery.

At the discretion of our physicians, patients may be dismissed from our clinic due to repeated failure to show up for scheduled appointments.

## FMLA Paperwork Policy

FMLA paperwork will be completed in the clinic within 7-10 business days. There will also be a $25 charge for each set of papers.

---

I have read and understand the above processes and any questions I have regarding these policies have been answered.

_____ _____

Printed Patient Name or Legal Guardian | Date of Birth

_____ _____

Signature of Patient or Legal Guardian | Date Signed

Relationship to patient (if signed by legal guardian): _____

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Arkansas Urogynecology & WOMEN'S HEALTH

# Patient Financial Policy: Patient Responsibility

**Purpose:**

To provide clear guidelines on the financial responsibilities of patients receiving services at Arkansas Urogynecology and Women's Health and ensure timely payment for medical services rendered.

**Patient Financial Responsibility:**

As a patient of Arkansas Urogynecology and Women's Health, you are responsible for payment of all services provided by our clinic. This includes any amounts not covered by your insurance plan, such as co-pays, co-insurance, deductibles, and services deemed non-covered by your insurance.

**Agreement to Pay:**

By receiving care at Arkansas Urogynecology and Women's Health, you acknowledge and agree to the following:

**Insurance Coverage and Responsibility:**

You understand that your insurance policy is a contract between you and your insurance provider. Arkansas Urogynecology and Women's Health is not a party to that contract.

It is your responsibility to understand your insurance benefits, including covered services, co-pays, co-insurance, and deductible amounts.

**Payment for Services:**

You agree to pay any amounts that are your responsibility under the terms of your insurance plan, including but not limited to:

Co-pays: Due at the time of service.

Co-insurance and Deductibles: Billed after your insurance processes the claim. You are responsible for paying these amounts promptly.

Non-covered Services: You will be responsible for payment in full for any services not covered by your insurance plan.

**Pre-authorization and Referrals:**

It is your responsibility to ensure that any required pre-authorizations or referrals are obtained prior to your appointment. Failure to do so may result in reduced coverage or denial of claims by your insurance.

**Payment Methods**:

Payment is expected at the time of service for all co-pays and any non-covered services.

We accept cash, credit/debit cards, checks, and electronic payments through our patient portal.

**Statements and Billing:**

You will receive a statement for any unpaid balances after your insurance claim has been processed. Full payment is expected within 30 days of receiving your statement.

**Payment Plans and Financial Assistance:**

If you are unable to pay the full balance at once, you may contact our billing department to discuss payment plan options.

Financial assistance may be available for those who qualify under our financial hardship policy. Please inquire with our billing department for more details.

**Delinquent Accounts:**

Accounts that are not paid within 60 days may be considered delinquent and subject to collection efforts, including being referred to a collection agency.

Collection Fees: It is further agreed that the undersigned shall pay all costs of collection, including reasonable attorney's fees, court cost, collection agency fees, late charges, and interest on any amount due or declared to be due, and placed with an attorney or collection agency for collection, on failure to pay any balance due. The balance due shall bear interest at the maximum rate allowed by law.

**Patient Acknowledgment:**

By signing this policy, you acknowledge that you understand and agree to these terms and accept financial responsibility for all services rendered by Arkansas Urogynecology and Women's Health.

**Effective Date:**

This policy is effective as of October 1, 2024.

**Approval:**

Arkansas Urogynecology and Women's Health Management

Patient Name: _____

Patient Signature: _____

Date: _____