FLORIDA BLADDER INSTITUTE

CSI | Division of Comprehensive Surgery Institute

Patient History Questionnaire

Patient Name: _____

DOB: _____

Date: _____

Past Medical History

No medical history ☐

Anemia	☐ Yes	Urinary Disorder	☐ Yes
Complications with Anesthesia	☐ Yes	Immunological Disease	☐ Yes
Cancer	☐ Yes	Heart Disease	☐ Yes
Diabetes	☐ Yes	Kidney Disease	☐ Yes
Endometriosis	☐ Yes	Lung Disease	☐ Yes
Fibromyalgia	☐ Yes	Liver Disease	☐ Yes
Hepatitis	☐ Yes	Neurological Disease	☐ Yes
Stroke	☐ Yes	Psychiatric Illness	☐ Yes
Bleeding/Clotting Disorder	☐ Yes	Gastrointestinal Disease	☐ Yes
Thyroid Issues	☐ Yes		

Notes: _____

Surgical History

No surgical history ☐

Have had any of the following surgeries? ☐ Yes

Hysterectomy	☐ Yes	Date: _____
Colon Surgery	☐ Yes	Date: _____
Endometriosis Surgery	☐ Yes	Date: _____
Bladder Botox	☐ Yes	Date:_____

Axonics ☐ Yes Date:_____

Urgent PC ☐ Yes Date: _____

Prolapse Repair ☐ Yes Date: _____

Removal of tubes/ovaries ☐ Yes Date: _____

Sling ☐ Yes Date:_____

Other Surgeries/Date:

_____

_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Alcohol Use ☐ Yes

Number of Drinks / Week: _____

Recreational Drug Use ☐ Yes

Smoking Status: ☐ Current ☐ Former ☐ Never

Occupation: _____

Family History

Diabetes: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Heart Disease: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

High Blood Pressure: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Kidney Disease: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Stroke: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

BRCA positive: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Bleeding/Clotting disorders: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Breast Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Ovarian cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Notes: _____

Medications History - have you ever taken any of the following:

Oxybutynin	☐ Yes	Tolterodine	☐ Yes
Solifenacin	☐ Yes	Mirabegron	☐ Yes
Fesoterodine	☐ Yes	Gemtesa	☐ Yes
Darifenacin	☐ Yes	Oxytrol	☐ Yes
Gelnique	☐ Yes		

**********Please List Other Current Medications**********

_____

_____

_____

Allergic History

No Known Drug Allergy ☐ Yes

Drug Allergy/Reaction: _____

Non-Drug Allergy/Reaction: _____

Type of reaction: _____

Gyn History

Are you menopausal? ☐ Yes

Are you sexually active? ☐ Yes

Are you using contraception? ☐ Yes

Type of contraception: _____

How many babies: _____

# of vaginal deliveries: _____

# of C-Section: _____

Sexually Transmitted Disease ☐ Yes

Type of Sexually Transmitted Disease: _____

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Financial Information

As a courtesy to you, we will be happy to bill your insurance company for services rendered. If, for any reason, your insurance company denies the claim, you will be personally responsible for the charges. A credit card is required to be kept on file for any charges not covered by insurance. Due to the thousands of insurance plans available it is impossible for us to know the coverage details of all of the policies. It is your responsibility to know what type of coverage, benefits, deductibles, and co-payments you have with your insurance plan.

Pathology Notice: Certain tests that you have done in the office will be sent to a pathologist for diagnostic evaluation. The pathologist will submit a bill to your insurance company and bill you directly if there is a balance due.

Phone Calls: We encourage you to use the patient portal to communicate with your provider concerning health questions. Communication through the patient portal is more efficient and will allow you access to your information 24 hours a day.

Surgery Cancellation Policy: A fee of $500.00 will be charged if you cancel a scheduled surgical procedure with less than a 10-day notice.

No Show and Late Arrival Policy: A fee of $50.00 will be charged for "No Show" Appointments, or appointments cancelled within 24 hours of your appointment time. Subsequent occurrences may result in dismissal from the practice. If you are more than 10 minutes late, the appointment may need to be rescheduled

In-Office Procedures: In-office procedures canceled with less than 24 hours notice will incur a $250 charge.

Assignment to Pay for Services: I agree to pay the Florida Bladder Institute for all charges for services rendered today, or on any future date of service in this office. I understand that any unpaid charges will be billed to my credit card. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney's fees, and/or court costs.

I agree to receive communications via text and email.

Please Note, a 3% convenience fee will be added for all credit card transactions.

I agree with all of the statements above.

Patient Signature :

Date:

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New Patient Information

All payments are due at the time of service. Charges will be billed to your insurance carrier.

Forms of payment accepted: Cash, Check, Money Order, Visa, MasterCard, American Express, and Discover

Name of Patient /Representative:

Date

Patient/Representative Signature: *

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Florida Bladder Institute to furnish information to all insurance carriers concerning my illness and treatments, and hereby assign all payments for medical services rendered to myself or my dependents to Florida Bladder Institute. I understand that I am responsible for any amount not covered by my insurance. In the event that an outside collection agency is necessary to enforce payment of the account, I agree to pay for all collection fees deemed reasonable.

Patient Signature : *

Sign Here

Patients are encouraged to use the patient portal which can be found at www.FloridaBladderInstitute.com. You can update your demographic and insurance information, access your health records, see your billing statements and send messages 24 hours a day on the patient portal. Please make sure all of your patient paperwork is filled out correctly and changes updated prior to your appointment or it may cause delays.

Thank you,

Florida Bladder Institute.

Date

MM-DD-YYYY

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Consent for Pelvic Exam

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or incontinence. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women), or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have AH pelvic examinations performed at this office, and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

Sign:_____ Date: _____

FLORIDA BLADDER
INSTITUTE
Urogynecology & Reconstructive Pelvic Surgery
1890 SW Health Pkwy, Suite 205, Naples FL 34109 OFFICE 239-449-7979 FAX 239-593-3356
www.FloridaBladderInstitute.com
CSI | Division of Comprehensive Surgery Institute

Consent for Purpose of Treatment, Payment or Health Care Operations And Medical Information Release (HIPAA)

I consent to the use or disclosure of my protected health information by Liberman Advanced Surgical (FBI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conducting health care operations of FBI. I understand that the diagnosis or treatment of me by FBI may be conditioned upon my consent, as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. FBI is not required to agree to the restrictions that I may request. However, if FBI agrees to a restriction that I request, the restriction is binding on FBI practice. I have the right to revoke this Consent in writing, at any time, except to the extent that FBI practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and collected or received by my Provider, another health care provider, a health plan, my employer, or a healthcare clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices for FBI prior to signing this document. Notice of Privacy Practices for FBI has been provided to me.

The Notice of Privacy Practices for FBI practice describes the types of uses and disclosures of my protected health information that FBI occur in my treatment, payment of my bills, or the performance of FBI health care operations.

A summary of the Notice of Privacy Practices for FBI is also posted in the waiting room.

This Notice of Privacy Practices for the FBI also describes my rights and the duties of FBI practice with respect to my protected health information.

FBI reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for FBI. I may obtain a revised Notice of Privacy Practices for FBI by contacting the office of FBI at 1890 SW Health Parkway, Suite 205, Naples. FL 34109 or by calling (239)264-7150.

Release of Medical information: If you would like us to give out Information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of Information each person may receive by checking the items we may release.

NAME	RELATIONSHIP	ALL INFO	APP ONLY	BILLING

Please list your primary care and referring physician and their Phone number and Fax number.

Referring Physician _____

Phone Number _____

Fax Number _____

Primary Car Physician _____

Phone Number _____

Fax Number _____

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AI Consent Form

Date:

Patient Name:

Date of Birth:

Use of AI in Care

Our office will be using Artificial Intelligence (AI) tools to help with documentation, communication, and administrative tasks. All medical decisions are made by your healthcare provider. The conversation will be recorded for charting purposes only.

Privacy

AI tools used by our practice follow HIPAA privacy and security guidelines. Your provider will review all AI-assisted information before it is added to your record.

Please select the following:

- ☐ I consent to the use of AI-assisted tools as part of my care.
- ☐ I do NOT consent to the use of AI-assisted tools for my care.
- ☐ I consent to the access and use of my medications history for treatment and care purposes.

Patient/Representative Signature_____

Printed Name: _____

Relationship (if not patient): _____

Date: _____