MEDICATION REFILL REQUESTS

Please allow us 2 business days for your prescription refill request to be processed.

For accurate renewal of your prescriptions, please be prepared to tell us:

- The name of the medication
- The dose and frequency of the medication
  (example: "20 mg one tablet twice a day")
- The prescription number off of the pill bottle label
- The name and phone number of your preferred pharmacy

****Medication refill requests will only be accepted during regular business hours****

Please call your pharmacy to confirm the prescription has been approved!

Thank you for your assistance!

Beacon Medical Group Center for Pelvic Health & Gynecology
707 N. Michigan Street, Suite 102
South Bend, IN 46601
(574)367-3800

INITIAL PATIENT SELF-HISTORY FORM

Provide all information requested to the best of your ability.

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

ALLERGIES (Include medications, Latex, Iodine)

_____

GYNECOLOGIC HISTORY

Age at first menses (period) _____ Age at menopause (if applicable) _____

(The following questions refer to your "natural" periods when not on birth control pills or hormones)

Usual # of days of period _____ Period interval (1st day to 1st day) _____ days

How many days are: Heavy _____ Medium _____ Light _____

Have you ever had an abnormal pap smear? _____

If yes, how was it treated? _____ When? _____

Date of last pap smear _____ Have you had a mammogram? _____ When? _____ Result _____

Types of birth control used, including vasectomy _____

Gynecologic Surgery: (Including Tubal Ligations, D&C's, Cryo, Leep, Ovarian surgery)

TYPE	WHEN	DOCTOR	COMPLICATIONS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? _____

PREGNANCY HISTORY

of pregnancies _____ # of premature deliveries _____ # of miscarriages _____ Was surgery needed? _____

# of abortions _____ Any complications? _____ Any "tubal" pregnancies? ____ When? _____

# of vaginal deliveries _____ # of Cesarean sections _____ Years of deliveries _____

Any serious complications during your pregnancies or deliveries? _____

_____

RISK FACTORS

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? _____ Do you smoke? _____ How much? _____ How many years? _____

Do you consume alcohol? _____ How often? _____

Have you ever used marijuana, cocaine, heroin, barbituates, or speed? _____ If yes, last used? _____ Any needles? _____

Age at first intercourse _____ Total # of sexual partners _____ Total # of sexual partners in last year _____

Have you had any sexually transmitted infections? _____ If yes, what? _____ When? _____

Do you believe yourself to be at risk of exposure to the AIDS virus? _____

OTHER SURGERY (not gynecologic)

TYPE	WHEN	DOCTOR	COMPLICATIONS

HOSPITALIZATIONS (Non-surgical, other than pregnancy)

CONDITION	WHEN	DOCTOR	TREATMENT

PAST AND PRESENT MEDICAL PROBLEMS

- ☐ **Abnormal PAP, h/o**
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bartholin's gland cyst
- ☐ Blood transfusion, h/o
- ☐ Breast cancer
- ☐ Breast mass
- ☐ Bruising / bleeding disorder
- ☐ Cerebrovascular accident
- ☐ Cervical cancer
- ☐ Clotting disorder
- ☐ Coronary heart disease
- ☐ Cystocele
- ☐ Depression
- ☐ DES Exposure
- ☐ Diabetes mellitus
- ☐ Drug/alcohol use
- ☐ Endometriosis
- ☐ Family hx of genetic disorder
- ☐ Fetal death, prior
- ☐ Fibroid uterus
- ☐ Gallbladder disease
- ☐ Genital herpes, exposure
- ☐ Genital herpes, h/o
- ☐ Heart murmur
- ☐ Hemoglobinopathy
- ☐ Hepatitis/Liver disease
- ☐ Hypercoagulable disorder
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Incompetent cervix
- ☐ Infertility
- ☐ Neonatal death, prior
- ☐ Phlebitis
- ☐ Obesity
- ☐ Ovarian cancer
- ☐ Ovarian cyst
- ☐ PID
- ☐ Polycystic ovary syndrome
- ☐ Prolapsed uterus
- ☐ Premature rupture of membranes
- ☐ Preterm delivery, prior
- ☐ Psychiatric disease
- ☐ Pulmonary embolism
- ☐ Recurrent miscarriages
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Uterine cancer
- ☐ UTI, h/o recurrent
- ☐ Vaginal infections, recurrent
- ☐ STD

Other Medical/Surgery History not listed _____

_____

FAMILY HISTORY *Include Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), and Children (C) only.*

Diagnosis		⇩ Family member Indicated by M-Mother, F-Father, B-Brother, C-Child, etc.		
Alive and Well ☐			Diabetes	○ Yes ○ No ☐
Alcoholism	○ Yes ○ No ☐		Downs syndrome	○ Yes ○ No ☐
Asthma	○ Yes ○ No ☐		Hemophilia-A	○ Yes ○ No ☐
Autoimmune disorder	○ Yes ○ No ☐		Hyperlipidemia	○ Yes ○ No ☐
Breast cancer	○ Yes ○ No ☐		Hypertension	○ Yes ○ No ☐
Cervical cancer	○ Yes ○ No ☐		Mental illness	○ Yes ○ No ☐
Coagulopathy	○ Yes ○ No ☐		Mental retardation	○ Yes ○ No ☐
Colon cancer	○ Yes ○ No ☐		Muscular dystrophy	○ Yes ○ No ☐
Coronary artery disease	○ Yes ○ No ☐		Ovarian cancer	○ Yes ○ No ☐
Cerebrovascular accident	○ Yes ○ No ☐		Seizure disorder	○ Yes ○ No ☐
Cystic fibrosis	○ Yes ○ No ☐		Sickle cell disease	○ Yes ○ No ☐
Depression	○ Yes ○ No ☐		Spina bifida	○ Yes ○ No ☐
Developmental delay	○ Yes ○ No ☐		Thyroid disease	○ Yes ○ No ☐
			Other ☐	○ Yes ○ No ☐

Other Family History not listed _____

_____ Check if adopted/family history unknown ☐

Beacon Medical Group Center for Pelvic Health & Gynecology
707 N. MICHIGAN STREET, SUITE 102 SOUTH BEND, IN 46601

Patient Name: _____ Age at menopause (if applicable): _____
Date of Birth: _____ Last menstrual period: _____

Ag **Please check all that apply to you TODAY**

Constitutional:
Weakness/Fatigue? _____
Fever? _____
Weight Gain? _____
Weight Loss? _____

HEENT:
Difficulty Hearing? _____
Mouth Sores? _____
Ear Pain? _____
Ringing in Ears? _____
Sinus Problems? _____
Sore Throat? _____
Vision Changes? _____
Blurred or Double Vision? _____

Respiratory:
Cough? _____
Shortness of Breath? _____
Wheezing? _____
Painful Breathing? _____

Cardiovascular:
Chest Pain? _____
Palpatations? _____
Leg Swelling? _____

Gastrointestinal:
Blood in Stool? _____
Constipation? _____
Diarrhea? _____
Nausea? _____
Vomiting? _____

Genitourinary:
Irregular Periods? _____
Painful Intercourse? _____
Vaginal Discharge? _____
Infertility? _____
Hot Flashes? _____
Frequent Urination? _____
Burning with Urination? _____
Leaking of Urine? _____
Blood in Urine? _____

Metabolic/Endocrine:
Cold Intolerance? _____
Heat Intolerance? _____
Increased Thirst? _____

Neuro/Psychiatric:
Anxiety? _____
Depression? _____
Frequent Headaches? _____
Dizziness? _____
Numbness? _____
Memory Difficulty? _____
Seizures? _____

Musculoskeletal:
Difficulty Walking? _____
Joint Pain? _____
Muscle Weakness? _____
Muscle Pain? _____

Hematology:
Easy Bruising? _____
Abnormal Bleeding? _____

Dermatologic:
Breast Pain? _____
Breast Lump? _____
Nipple Discharge? _____
New/Changed Mole(s)? _____
Hair Loss? _____
Rash/Skin Sore(s)? _____
Allergies? _____
If Yes, please list: _____
_____
_____

History of drug use? _____
Smoker? _____
If Yes, How Much? _____
Alcohol? _____
How many drinks per wk? _____

Reviewed by: _____

Beacon Medical Group Center for Pelvic Health & Gynecology
707 N. Michigan Street, Suite 102 South Bend, IN 46601

Urinary Assessment Sheet

Name: _____ **Date of Birth:** ____/____/____ **Today's Date**____/____/_____

	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost Always	Your Answer
Urinary Stress Incontinence Over the past month, how often have you experienced an involuntary loss of urine when you coughed, sneezed or changed position?	0	1	2	3	4	5	
Urinary Urgency Incontinence Over the past month, how often have you had an involuntary loss of urine when you had a sudden urge to urinate?	0	1	2	3	4	5	

If you have experienced an involuntary loss of urine, please answer the following questions:

When did you first experience urinary incontinence? _____
Do you use pads to due to urinary leakage? ☐ No ☐ Yes Type_____ # pads daily ____ ☐ damp ☐ soaked
If you have both stress and urgency urinary incontinence which type bothers you the most? ☐ Stress ☐ Urgency
Have you experienced any skin irritation as a result of urinary incontinence? ☐ No ☐ Yes

Diet and Lifestyle:

1. How many ounces of fluid do you drink in 24 hours? _____
2. What type of fluid do you drink? _____
3. Have you ever smoked, or are you currently smoking? ☐ Never ☐ Quit _____ ☐ Yes ____pack/day _____years
4. If you have gained weight, have your symptoms worsened since you gained weight? ☐ No ☐ Yes

Past History:

Have you given birth? ☐ No ☐ Yes → # of Children _____ Type of Delivery ☐ Vaginal ☐ C-Section
Do you have trouble with constipation? ☐ No ☐ Yes
Have you ever had any surgery to correct urinary leakage? ☐ No ☐ Yes → When? _____
Type of surgery _____
Have you taken any medications to treat urinary leakage? ☐ No ☐ Yes →
Name of Medication(s)_____
Are you still taking the medication? ☐ No ☐ Yes → Name of Medication_____
Have medications helped? ☐ No ☐ Yes
Have you had a urinary tract infection? ☐ No ☐ Yes →How often? _____
Have you tried other treatments to improve urinary control? ☐ No ☐ Yes → Explain _____
_____

Quality of Life Due to Urinary Incontinence

	Very Pleased	Pleased	Mostly satisfied	Mixed feelings	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary incontinence just the way it is now, how would you feel about it?							

Reviewed by: _____

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Laboratory Specimen Handling

We try our best to be knowledgeable in regard to most major insurance carriers' requirements, however many plans are different based on the preferences of the employer. It is important for you to understand your plan's coverage and for you notify us at the time of your appointment if your insurance requires your laboratory specimens to be sent to either Quest Diagnostic Laboratories or Lab Corp.

Failed Appointment Policy

If you are unable to keep your schedule appointment, we ask that you inform us at least 24 hours in advance. This will allow our office to schedule patients that are having acute problems. Failed appointments affect the flow of the office and create many inconveniences to our practice and patients.

We consider a failed appointment to be: canceling on short notice (less than 4 hours prior to your scheduled appointment time), failing to arrive at the office for your appointment, or arriving too late to be seen (more than 15 minutes).

New patients who fail to keep their first appointment with the physician will only be rescheduled once. If the patient fails to keep the second appointment, additional appointments may not be rescheduled in the practice. Established patients who fail the first appointment will receive a reminder letter to reschedule the appointment. Should the patient fail a second appointment, we will send you a second letter notifying you that a third missed appointment may result in dismissal from the practice.

If the established patient fails to keep three appointments within one-year, dismissal from the physician may occur. A letter will be sent informing the patient that we will provide 30 days emergency care only. During that time, we recommend the patient find another physician to provide them medical care. We will then transfer the medical record upon receipt of a signed request with the new physicians name and address.

Medication Refill Requests

Please allow 2 business days for your prescription refill request to be processed. For accurate renewal of your prescriptions, please be prepared to tell us:

- The name of the medication
- The dose and frequency of the medication
  - (example: "20 mg one tablet twice a day")
- The prescription number off of the pill bottle label
- The name and phone number of your preferred pharmacy

Please call your pharmacy to confirm the prescription has been approved. Please note: Medication refill requests will only be accepted during regular business hours.

My signature indicates that I have read and understand the important information listed above.

_____ _____

Patient/Parent or Legal Guardian Signature Date

_____

Printed Name of Patient

BEACON™
HEALTH SYSTEM

RELEASE OF VERBAL MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** ____/____/____

The purpose of the Release of Verbal Medical Information forms is to provide our patients an opportunity to permit verbal release of Protected Health Information (PHI) in the following two (2) ways (this does not authorize release of copies of medical records):

1. Permission to verbally discuss PHI with family members/caregivers

I hereby authorize medical providers and personnel of Beacon Health System to discuss my protected health information with the following person(s):

Name: _____

Primary Phone: _____ **Relationship:** _____

Name: _____

Primary Phone: _____ **Relationship:** _____

(OR) ☐ **I decline.** Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

2. Permission to leave message

Please circle YES or NO for the following statements. By circling YES, Beacon Health System will leave voicemail or answering machine messages at your home, work, or emergency contact on file that may include your protected health information and that may be overheard by others not involved in your care.

Place	Callback / Message	Detailed Message
Home	Yes / No	Yes / No
Work	Yes / No	Yes / No
Emergency Contact	Yes / No	Yes / No

- This authorization applies to all Beacon Health System providers.
- This authorization will remain in effect until revoked or changed.
- I understand that such revocation is not effective to the extent that the clinic has relied on the use of disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and my no longer be protected by state or federal law.
- This form is not valid unless signed and dated.

_____ _____
Signature of Patient/Personal Representative | Printed Name of Patient/Personal Representative

_____ _____
Date | Relationship to the Patient

BEACON
HEALTH SYSTEM

CONSENT FOR TREATMENT - ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name: _____ **DOB:** _____/_____/_____

1. **CONSENT TO TREAT:** I authorize my treating physician and other healthcare providers to order for me all forms of diagnostic testing and treatment which they judge to be appropriate. I request and authorize Beacon Medical Group and Its agents and employees, to provide all treatment services to me as directed by my physicians. I acknowledge that no representation or guarantees have been made to me as a result of the treatment of care.

2. **ASSIGNMENT AND RELEASE:** I have medical insurance and assign directly to Beacon Medical Group physicians all medical benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. In the event of default of payment, I agree to pay all costs of collections including attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all my insurance submissions.

3. **FINANCIAL AGREEMENT:** I will make every effort to actively assist Beacon Medical Group with securing payment for services rendered for which I am liable. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third party payer agreements, I am financially responsible for all services rendered, and that the parent who authorizes treatment will be responsible for any balance due. I understand that Beacon Medical Group submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made. I understand that my third-party payer may require me to obtain prior/post-authorization in order to cover services. I understand that if I do not provide sufficient and timely information and releases of information for Beacon Medical Group to process insurance claims, I will be responsible to pay Beacon Medical Group full and standard fees. I consent to receiving auto-dialed and/or artificial or prerecorded message calls to my cellular and/or line telephones from Beacon Medical Group or its contracted agencies.

4. **STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN):** I request that payment of authorized Medicare benefits be made on my behalf to Beacon Medical Group for services furnished to me by a Beacon Medical Group clinic, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and Its agents any information needed to determine these benefits or benefits for related services.

5. **STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER (PHYSICIAN):** I request that payment of authorized MediGap benefits be made on my behalf for any services furnished to me by a Beacon Medical Group clinic, including physician services. I authorize any holder of medical information about me to release to (My Insurer) any information needed to determine these benefits or the benefits payable for related services.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

This consent/authorization will remain in effect until revoked by responsible party.

_____	_____	____/____/____
Printed Name of Patient/Authorized Representative	Signature of Patient/Authorized Representative	Date

RECEIPT OF HIPAA PRIVACY NOTICE: I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice". I understand the Notice of Privacy may change over time and that the obligations of Beacon Health System, Inc. and my rights under it may change.

INITIAL: _____

BEACON
MEDICAL GROUP

Written Notice of Potential Out-of-Network Charges

Beacon Medical Group values our patients. We want to ensure that our patients receive the best care and have an exceptional experience. This may mean that your Beacon Medical Group provider may refer you to a different provider for more specialized care and/or testing. **It is up to you to evaluate whether the provider you are being referred to for specialized care and/or testing is part of your insurance network (in-network) BEFORE your visit.**

> *(1) An out-of-network provider may be called upon to render health care items or services to the covered individual during the course of treatment.*

Most insurance plans have a phone number that patients can call to verify whether the provider they are being referred to is "in-network" or "out-of-network" and to provide other assistance. Insurance providers can also provide a list of "in-network" providers that may render the specialized care and/or testing required.

If your insurance confirms the provider you are being referred to is "in-network", this means your insurance plan has negotiated a rate with this provider and all or part of the cost should be paid by your insurance. Each insurance plan is different, so for detailed information please contact your insurance provider.

If your insurance confirms the provider you are being referred to is "out-of-network", this means there is potential to have a greater out-of-pocket cost for care from this provider. This is because an out-of-network provider is not bound by the payment terms of your health plan. It will be up to you to decide whether you want to visit this provider or work with the referring provider and your insurance to find an "in-network" provider.

> *(2) That an out-of-network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.*
> *(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out-of-network provider described in subdivision:*
> *(A) to obtain a list of network providers that may render the health care items or services; and*
> *(B) for additional assistance.*

Beacon Medical Group wants to ensure you are informed of these options prior to being referred for specialized care and/or testing.

Your signature below indicates that you received this information and understand your options.

_____ _____

Patient Name (please print) Patient Date of Birth

_____ _____

Signature of Patient, Guardian or Legal Representative Today's Date