

BLADDER SATISFACTION SURVEY

Name _____ Phone # _____

Doctor _____

Which symptoms best describe you?

- | | |
|--|---|
| <input type="checkbox"/> Frequent Urination – Day, Night, or Both
<input type="checkbox"/> Sudden or Strong Urge to urinate
<input type="checkbox"/> Unable to Empty the Bladder | <input type="checkbox"/> Leaking with Sneezing, Coughing, Exercising
<input type="checkbox"/> Leaking with Urge or No Warning (Unable to make it to the bathroom in time)
<input type="checkbox"/> Bladder or Pelvic Pain |
|--|---|

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

- | | | | |
|--|--------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Detrol LA | <input type="checkbox"/> Ditropan XL | <input type="checkbox"/> Flomax | <input type="checkbox"/> Cardura |
| <input type="checkbox"/> Oxytrol Patch | <input type="checkbox"/> Enablex | <input type="checkbox"/> Vesicare | <input type="checkbox"/> DDAVP |
| <input type="checkbox"/> Sanctura | <input type="checkbox"/> Elavil | <input type="checkbox"/> Elmiron | <input type="checkbox"/> Other _____ |

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10	
No Relief								Completely Cured			

If you've stopped taking your meds explain why:

- Did not Help Side Effects Too Expensive

Describe Side Effects _____

Behavior Modifications Tried _____

(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10	
Not Frustrated								Very Frustrated			

Do you currently have any problems with bowel function?:

- Fecal Incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications:

- Yes No

Dear patient:

We would like to take this opportunity to welcome you to our practice to provide your urological care. We appreciate your trust and look forward to keeping you healthy and happy.

As part of our services, we try to contain the ever-rising cost of health care. To do this, we have implemented this Financial Policy which we ask you to read and sign. You may receive a copy of this policy for your records if you so desire. The original will be maintained in your medical record.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you, our staff will contact your insurance company to verify your coverage benefits regarding medical care. We will make every effort to advise you if uncertain treatments are not covered by your plan. In doing this, we must rely on the information provided to us by your insurance company representatives. We do document the person we speak to and the date of the call. However, we cannot be responsible if we are given the false information by your company although this is rare. Verification of coverage and eligibility IS NOT a guarantee that payments will be made by your insurance company. That is determined by your insurance company at the time the claim is submitted and reviewed. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you ever have any questions regarding your coverage, we will be happy to assist you in obtaining the answers. Ultimately, YOU are responsible for all costs uncured during treatment, with the expectation of PPO, HMO, or Preferred Provider adjustments and write-offs. These adjustments and write-offs are determined by the contracts we have with your insurance company.

CO-PAYMENTS AND DEDUCTIBLES

Although we accept assignment of insurance benefits as determined by our PPO, HMO, and Preferred Provider contracts with the various insurance companies and medical groups, we do require co-payments, patient portion amounts, and any unpaid yearly deductibles to be made at the time of service.

UNINSURED PATIENTS

FULL payment is due at the time of service. We do accept card, cash, and checks.

NON-COVERED BENEFITS

We realize unforeseen circumstances may arise or that some insurance companies, especially HMO's, may not cover some medically necessary services. In these instances, a payment plan may be available. These will be evaluated on a case by case basis. While we try to accommodate all our patients, we do maintain strict guidelines regarding payment plans. Failure to adhere to the payment schedule will result in a revocation of the payment plan agreement.

BALANCES AND STATEMENTS

You will receive a statement at the end of each month. If any payment is due, the statement will have a "Pay this amount" section on it. This payment is due by the fifteenth of the month. If this payment has not been received by the next billing cycle, a re-billing fee of \$15.00 will be added to your balance. This will be repeated each month. If you have difficulty making a payment, you MUST contact us PRIOR to the due date to avoid these fees.

In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of the practice. We are dedicated to providing you and your family with the best possible care available. We will also attempt to accommodate you whenever possible. If you have any questions regarding this financial policy or any other matter, please contact the office manager. Thank you for the understanding. We look forward to serving all your urological needs.

I, _____ have read this financial policy, understand it, and agree to its terms

Signature: _____

Date: ____/____/____