Keil Urogynecology

4600 Hale Parkway. Ste. 350 Denver, CO 80220
(303)329-5822

New Patient Welcome

Dear Patient,

Welcome! Your first visit with us is _____ , _____ at _____. Please come in at _____. This extra 15 minutes is for you to complete our patient registration form.

If you are more than 15 minutes late, we may ask you to reschedule your appointment.

Enclosed you will find a questionnaire and a 24 hour bladder diary. It is very important for you to complete these prior to your arrival at our office. Please do not try to complete the questionnaire in our waiting room. We believe you will complete it better in your own environment and time frame. This information will help us to properly evaluate you and your concerns. We will not be able to see you if the questionnaire is not completed.

The 24 hour bladder diary is also important. This also needs to be completed on a day prior to your arrival at our offices. Complete all of the columns as explained. If you have questions, you may call our office.

When you come to your appointment, **bring: your insurance card**. If you do not have insurance information, payment will be expected at the time of service. With insurance information, a co-payment is due at the time of service, **we only take cash or check.** If copay is not paid at the time of service you will be charged a $40 processing fee. If you are not sure about how to get a referral, call your primary care provider and be sure to inform your insurance company the specific problem that you have. We need a referral to see and treat you. The only time you not need a referral is for an annual gynecological exam including a pap smear and a breast exam.

If you need to cancel your appointment we ask that you notify us as soon as possible. **If you no show for the appointment or cancel without a 24 hour notice, you personally will be billed for your time reservation at a rate of $50 per visit. Your insurance company will not pay this fee.**

Due to technical issues and concerns for safety we ask you to make child care arrangements for your visit. There are directions on the back of this letter that will help you to locate our office. You may park in the Rose Medical Center parking garage across the street from our building and there is a valet available in front of our building.

Thank you in advance for you time in completing the questionnaire, bladder diary and insurance information. This will help us provide you with the best medical care possible. We look forward to our future meeting.

Keil Urogynecology

4600 Hale Parkway Suite 350 Denver, CO 80220
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Directions

From the North:

Take I-25 South to I-70 East. I-70 East to Colorado Blvd. Colorado Blvd South to 12th Ave. East on 12th Ave (12th turns into Hale Parkway) to Cleremont.

From the South:

Take I-25 North to Colorado Blvd. Go North on Colorado Blvd. to 12th Ave. 12th Ave. (12th Turns int Hale Parkway) East to Clermont.

Our office building and valet will be located on your right and the parking garage will be on your left. Please allow an extra ten minutes for parking. We also ask every patient to leave a urine sample at every visit so please be ready to do so at check in.

Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble. The "sample" line shows you how to use the diary.

Your name: _____

Date: _____

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	*How much?*	*How many times?*	*How much urine? (circle one)*	*How much? (circle one)*	*Circle one*	*Sneezing, exercising having sex, lifting, etc.*
Sample	Coffee	2 cups	✓✓	(sm) med lg	sm (med) lg	Yes (No)	Running
6–7 a.m.				sm med lg	sm med lg	Yes No	
7–8 a.m.				sm med lg	sm med lg	Yes No	
8–9 a.m.				sm med lg	sm med lg	Yes No	
9–10 a.m.				sm med lg	sm med lg	Yes No	
10–11 a.m.				sm med lg	sm med lg	Yes No	
11–12 noon				sm med lg	sm med lg	Yes No	
12–1 p.m.				sm med lg	sm med lg	Yes No	
1–2 p.m.				sm med lg	sm med lg	Yes No	
2–3 p.m.				sm med lg	sm med lg	Yes No	
3–4 p.m.				sm med lg	sm med lg	Yes No	
4–5 p.m				sm med lg	sm med lg	Yes No	
5–6 p.m.				sm med lg	sm med lg	Yes No	
6–7 p.m.				sm med lg	sm med lg	Yes No	

Use this sheet as a master for making copies that you can use as a bladder diary for as many days as you need.

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	*How much?*	*How many times?*	*How much urine? (circle one)*	*How much? (circle one)*	*Circle one*	*Sneezing, exercising having sex, lifting, etc.*
Sample	Soda	2 cans	✓✓	(sm) med lg	(sm) med lg	Yes (No)	Running
7–8 p.m.				sm med lg	sm med lg	Yes No	
8–9 p.m.				sm med lg	sm med lg	Yes No	
9–10 p.m.				sm med lg	sm med lg	Yes No	
10–11 p.m.				sm med lg	sm med lg	Yes No	
11–12 midnight				sm med lg	sm med lg	Yes No	
12–1 a.m.				sm med lg	sm med lg	Yes No	
1–2 a.m.				sm med lg	sm med lg	Yes No	
2–3 a.m.				sm med lg	sm med lg	Yes No	
3–4 a.m.				sm med lg	sm med lg	Yes No	
4–5 a.m.				sm med lg	sm med lg	Yes No	
5–6 a.m.				sm med lg	sm med lg	Yes No	

I used _____ pads today. I used _____ diapers today (write number).

Questions to ask my health care team: _____

_____

_____

_____

_____

Let's Talk About Bladder Control for Women is a public health awareness campaign conducted by the National Kidney and Urologic Diseases Information Clearinghouse (NKUDIC), an information dissemination service of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health.

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New Patient Medical History Questionnaire

PLEASE PRINT. THANK YOU! Date of Appointment____/____/____

Name:_____ DOB ____/____/_____
Referring Doctor:_____ Primary Care MD_____

What is the main reason for your visit? (check all that apply)
Urinary leakage with cough/sneeze/laugh Vaginal bulging (dropped bladder, uterus, rectum)
Frequent urination Bladder infections Dribbling after urination Pelvic/vaginal pain
Inability to postpone urination Vulvar pain Painful urination Constipation
Interstitial Cystitis Frequent urination at night Ovarian cysts Fibroids
Urethral cyst/diverticulum Unable to empty bladder Loss of bowel control
Other (please explain)_____

How long has this problem bothered you?)_____
What are your expectations in seeking help for this problem?
Complete cure Reduce severity of symptoms Complete diagnosis of problem
Other (please explain)_____

SURGICAL HISTORY

- Have you had any previous surgery for incontinence? No Yes
- Type and date: _____ ____/____/____
- Have you ever had a hysterectomy? No Yes Abdominal Vaginal
- Have your ovaries been removed? No Yes
- Have you had any other previous surgeries for pelvic prolapse/relaxation? No Yes
- Type and date: _____ ____/____/____
- Have you had any other procedures on the urinary tract? No Yes: if yes, please mark
  urethral dilation cystoscopy urodynamics (bladder testing)
  collagen injections bladder distension kidney stone treatment
- **Any other surgeries(heart, gall bladder, appendix, tubal ligation, etc.** No Yes
- Type and date _____ ____/____/____

GYNECOLOGIC HISTORY

- Describe your current periods: Regular Irregular Painful periods
  Heavy Premenopausal Post-menopause, Age:_____
- Date of last normal menstrual period____/____/____
- Date of last PAP smear: ____/____/____ Normal Abnormal
- Follow up for abnormal PAP: _____
- History of pelvic infections No Yes if yes, please explain_____
- Date of last colonoscopy screening ____/____/_____ None Normal Abnormal
- Date of last Mammogram ____/____/____ None Normal Abnormal

Provider Reviewed_____

OBSTETRIC HISTORY

- Total number of times pregnant: _____
- Have you had any vaginal deliveries? No Yes Number: _____
  Forceps assisted Episiotomy Largest baby:_____lbs. _____oz.
- Have you had any Cesarean deliveries? No Yes:: Number_____
- Any miscarriages? No Yes: Number_____ Abortions No Yes Number_____

MEDICAL HISTORY (please mark any that apply to you)

High blood pressure Heart disease Diabetes Thyroid IBS
Fibromyalgia Asthma/COPD Skin Dz Arthritis Cancer
Reflux/GERD Depression IBD/colitis Neurologic Kidney stones
Heart attack Blood Clots Back/spine/disk problems or pain

Please list any other conditions or details from those marked above_____

_____

_____

CURRENT MEDICATIONS (list all birth control, vitamins, over the counter, prescriptions along with dosage)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES (list allergies to medications and substances along with reaction)

No drug allergies **latex allergy** **Betadine/Iodine allergy**

_____

_____

_____

SOCIAL HISTORY AND HEALTH HABITS (check all that apply)

Occupation: _____

Marital Status: Married Single Divorced Widowed

Yes	No	Are you/do you	Notes
		A smoker?	Cigarettes per day: How many years?
		Drink alcohol	What type? How often?
		Use illegal drugs?	What type How often?
		Wear a seat belt?	
		Exercise regularly	What kind?
		Take extra Calcium?	
		Drink caffeine (coffee, tea)	Cups per day:
		Sexually active?	Male Female Both
		Do self breast exams SBEs	

Name:_____ Provider reviewed_____

Keil Urogynecology 4600 Hale Parkway Ste. 350 Denver, CO 80220 **Phone** (303)329-5822

FAMILY HISTORY Includes only biological parents, siblings and grandparents

Yes	No	Disease	Please list family member(s) with condition
		Heart disease	
		High blood pressure	
		Blood clots in legs/lungs	
		Stroke	
		Diabetes	
		Thyroid disease	
		Kidney disease	
		Cancer (please list type)	
		Arthritis	
		Mental Illness/Depression	
		Blood disease	
		Bladder or prolapse problems	
		Other	

Review of Systems

Do you NOW have any problems related to the following systems?

General **No problems**
Fever or chills Fatigue Weakness
Loss of appetite Headaches (frequent)
Weight gain amount _____, time_____
Weight loss amount _____, time_____

Eyes **No problems**
Vision change Glaucoma Cataracts
Glasses/contacts: Distance Reading
Double vision Other_____

Neurological **No problems**
Tremors Black-outs Seizures
Neuropathy Other_____

Endocrine **No Problems**
Diabetes Low thyroid Hyperthyroid
Hot flashes Heat/Cold intolerance
Chronic Fatigue Other_____

Gastrointestinal **No Problems**
Diarrhea Constipation Fecal incontinence
Indigestion Nausea/Vomiting Hepatitis
Rectal bleeding Abdominal Pain Blood in stool
Colon Polyps Other_____

Skin **No problems**
Rash Ulcers Other_____

Cardiovascular **No problems**
Chest pain Shortness of breath Swelling
Palpitation Shortness of breath with exertion
Blood clots High blood pressure Stroke
Other _____

Ear/Nose/Throat/Mouth **No problems**
Hearing loss Syncope Sinusitis
Migraines Seasonal Allergies Colds/cough
Other_____

Genitourinary **No Problems**
Urine retention Incomplete emptying of urine
Painful urination Blood in urine Incontinence
Urinary frequency Urinary urgency
Vaginal bulge Urinary tract infections (>3per year)
Frequent urination at night
Other _____

Gynecologic **No problems**
Abnormal vaginal discharge STD's
Pain with intercourse Irregular menses
Other_____

Lungs/Respiratory **No problems**
Wheezing Cough Asthma Emphysema
Pneumonia Coughing blood
Other_____

Hematological/Lymphatic **No problems**
Easily bruises Bleeding gums Swollen glands
HIV/AIDS Hepatitis Lymphoma
Blood transfusions when? ____/____/____
Other_____

Psychological **No problems**
Depression Anxiety Other_____

Musculoskeletal **No Problems**
Weakness Pain Arthritis Backache
Limited mobility Other_____

Name:_____ Provider reviewed_____

Intake Questionnaire

UDI-6

1) Do you experience, and if so, how much are you bothered by frequent urination?
   Not at all Slightly Moderately Greatly
2) Do you experience, and if so, how much are you bothered by urine leakage related to physical activity, coughing or sneezing?
   Not at all Slightly Moderately Greatly
3) Do you experience, and if so, how much are you bothered by urine leakage related to the feeling of urgency?
   Not at all Slightly Moderately Greatly
4) Do you experience, and if so, how much are you bothered by small amounts of urine leakage (drops)?
   Not at all Slightly Moderately Greatly
5) Do you experience, and if so, how much are you bothered by difficulty emptying your bladder?
   Not at all Slightly Moderately Greatly
6) Do you experience, and if so, how much are you bothered by pain or discomfort in the lower abdominal or genital area?
   Not at all Slightly Moderately Greatly

IIQ-7

1) Has urine leakage effected your ability to do household chores? (cooking, cleaning, laundry etc)
   Not at all Slightly Moderately Greatly
2) Has urine leakage effected your physical recreation such as walkin, swimming, pr other exercise?
   Not at all Slightly Moderately Greatly
3) Has urine leakage effected your entertainment activities? (movies, concerts etc)
   Not at all Slightly Moderately Greatly
4) Has urine leakage effected your ability to travel by car or bus more than 30 minutes from home?
   Not at all Slightly Moderately Greatly
5) Has urine leakage effected your participation in social activities outside your house?
   Not at all Slightly Moderately Greatly
6) Has urine leakage effected your emotional health? (Nervousness, depression etc)
   Not at all Slightly Moderately Greatly
7) Has urine leakage made you frustrated?
   Not at all Slightly Moderately Greatly
8) During an average day, how many times do you need to urinate? _____
9) During an average day, how often do you urinate? _____
10) During an average night, how often \do you get up to urinate?_____
11) During an average day, how many pads or diapers do you use?_____

Name:_____ Provider reviewed_____

Group Health Intake Form
KEIL UROGYNECOLOGY

Patient Information: **Today's Date:**_____

First Name:_____MI:____Last Name:_____DOB:_____

Address:_____Apt. No:_____City:_____State:_____Zip Code:_____

Hm Ph: (_____)_____ Cell Ph: (_____)_____ SSN:_____Marital Status: M S D W

Employment Status: (please circle) Employed Self Employed Unemployed Retired Student: F/T or P/T

Employer Name:_____Wk Ph: (_____)_____ Occupation:_____

Employer Address:_____City:_____State:_____Zip Code:_____

Emergency contact:_____Ph: (_____)_____Relationship:_____

(Someone other than spouse)

Spouse Information:

First Name:_____MI:____Last Name:_____DOB:_____

Cell Ph: (_____)_____Wk Ph: (_____)_____ SSN:_____

Primary Insurance and Responsible Party Information (All Fields Are REQUIRED- even with copy of card)

Insurance Name:_____**I.D.**_____**Group**_____

Cust. Svc. Ph:_____**Effective Date:**_____**Termination Date:**_____**Copay: $**_____

Billing Address:_____**City:**_____**State:**_____**Zip Code:**_____

Policy Holder Information: First Name:_____MI:____Last Name:_____

Address:_____Apt. No:_____City:_____State:_____Zip Code:_____

Hm Ph: (_____)_____ Cell Ph: (_____)_____ SSN:_____DOB:_____

Employer Name:_____Wk Ph: (_____)_____ Occupation:_____

Employer Address:_____City:_____State:_____Zip Code:_____

Secondary Insurance Information (All Fields Are REQUIRED- even with copy of card)

Insurance Name:_____**I.D.**_____**Group**_____

Cust. Svc. Ph:_____**Effective Date:**_____**Termination Date:**_____**Copay: $**_____

Billing Address:_____**City:**_____**State:**_____**Zip Code:**_____

Who referred you to our Practice?_____
If a Doctor, please provide a phone number: (_____)_____

DO YOU HAVE MEDICARE OR MEDICAID? (PLEASE CIRCLE ONE) YES NO

KEIL UROGYNECOLOGY

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following treatment::

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Keil Urogynecology** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Keil Urogynecology** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Keil Urogynecology.**

I acknowledge that I have been given **Keil Urogynecology** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature ***Date***

HOW CAN WE REACH YOU REGARDING

YOUR CONFIDENTIAL HEALTH ISSUES??

YOUR PHYSICIAN AND OTHER STAFF MEMBERS WILL, AT TIMES, NEED TO CONTACT YOU. BY LISTING METHODS OF REACHING YOU BELOW, WE WILL BE MORE SUCCESSFUL IN GETTING YOUR MEDICAL INFORMATION TO YOU OR YOUR DESIGNATED REPRESENTATIVES.

In effort to protect your privacy we have developed a policy for communicating your medical information:

*****WE WILL NOT SPEAK TO OR LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT AND/OR WHOMEVER THE PATIENT HAS DESIGNATED BELOW WITH A CHECK MARK.**

*****PLEASE WRITE DOWN NAME(S), RELATIONSHIPTO YOU, BEST NUMBER TO CALL, OF ANYONE INCLUDING YOURSELF, AND DECIDE WHETHER OR NOT IT IS APPROPRIATE TO LEAVE A VOICE MESSAGE.**

I _____**,** give Keil Urogynecology, and any member of the office staff, permission to leave my protected medical information with the person(s) designated below. I fully understand that this consent will remain in effect until revoked in writing. I also understand that it is my responsibility to inform the office staff of any changes I wish to make.

Name:	**Ok to leave voice message:**
You-Best # _____Alt.#_____	__yes___no
Spouse/Name_____	
Best #_____Alt.#_____	__yes___no
Relative/Name_____	
Relationship_____	
Best #_____Alt.#_____	__yes___no
Other/Name_____	
Relationship_____	
Best #_____Alt.#_____	__yes___no

Power of Attorney if applicable):

Name/Relationship_____

Best#_____Alt.#_____ __yes___no

Signature_____Date:_____

Advanced Urogynecology & Pelvic Surgery
4600 Hale Parkway, suite 350
Denver, CO 80220-3900
303-329-5822

Kristinell Keil, MD

Welcome to our practice we look forward to handling your care.

We would like to bring to your attention our clinic policies regarding miscellaneous fees.

Missed appointment/No show fee	$50.00
Cancelled visit--need 1 Business day notice	$50.00
Rebilling fee (monthly after 60 days)	$10.00
Returned check charge	$40.00
Copay rebill fee/ (Copay due at time of service)	$40.00

Printed Name: _____

Signed: _____

Date: _____

Keil Urogynecology

Dr. Kristinell Keil , M.D.

To our patients:

This is a brief explanation of how we run the office. We hope that this will open communication and prevent confusion.

Payment:

If you have a copay or co-insurance amount, that amount is expected at the time of service. **We accept checks and cash**. We also charge a $40 fee on all returned checks.

No Show and Cancellation Policy:

Effective July 1, 2009

We recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. This in mind, we have developed a ***No Show/Cancellation*** policy that is fair to both our patients and our practice. We are committed to seeing our patients on time and respecting their time. Late cancellations (notice less than 2 business days), missed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule, we request 2 business days notice for cancellations or rescheduling of appointments. In the instance of a missed appointment, late arrival or late cancellation (notice less than 2 business days) there **may** be a ***$50.00 No Show/ Cancellation Fee***.

Late Cancellations:

Late cancellations will be considered as a "No Show".

Patient Signature_____

Date_____

Check In

We **respect** and **value** your time. **We request that all of our patients arrive 15 minutes prior to their appointment for Check In.** If you are more than 15 minutes late, we may need to reschedule your appointment.

We apologize for any inconvenience this may cause you, but we hope that in the end, everyone will be served in a more timely and efficient fashion, while still receiving the highest quality care possible.

Please allow ten extra minutes for parking. We also ask every patient to leave a urine sample at every visit so please be ready to do so at check in.

Insurance referrals:

As the patient, it is my responsibility to understand the requirements of my insurance policy. If a referral is needed prior to seeing a specialist (Dr. Keil), it is my responsibility to obtain one through my primary care doctor. If I choose to be seen **WITHOUT** a valid referral in place, I understand that I am responsible for any charges not covered by my insurance company.

Patient Signature_____

Date_____

Updated 1/15/16

Financial Policy for KEIL UROGYNECOLOGY

KEIL UROGYNECOLOGY is committed to the accurate financial processing of your evaluation and treatment. We will ensure your financial information is handled reliably and efficiently, and is transmitted to your health insurance company in a timely manner.

Financial Policy:
For all medical services provided by KEIL UROGYNECOLOGY, payment is due at the time of service. For our patients with medical insurance coverage, co-pays and deductibles which have not been satisfied will be due at the time of service.

Insurance: KEIL UROGYNECOLOGY will only file the claim amount to the patient's primary and secondary insurance. After your insurance has processed the claim, all remaining amounts after contractual adjustments shall be the patient's responsibility. If your insurance fails to respond to a properly filed claim in 30 days, any remaining amounts shall be the patient responsibility and due in full.

We strongly recommend that you personally verify your own medical coverage within your policy. Please call the customer service number on your insurance card. The information required includes:

- What your co-pay, deductible and/or co-insurance is for medical services.
- What your co-pay, deductible and/or co-insurance is for medical procedures and surgery.

It is not guaranteed that insurance companies will pay for all services rendered and/or authorized. Should your insurance not pay for services provided by Keil Urogynecology the costs associated with your office visits, treatments, and surgery will be your responsibility. Keil Urogynecology reserves the right to take whatever legal or other action that is necessary to bring your account current, including but not limited to outside collection proceedings and/or termination from our practice. All accounts over 180 days will be turned over to collections.

In consideration of treatment by the doctors and nurse practitioners at Keil Urogynecology, I the undersigned-(s), jointly and severally, understand the terms and conditions above and without limitation agree to the following:

1. I am responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by KeilUrogynecology to me, my family, or other individuals I may have authorized. I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to Keil Urogynecology.
2. I will pay all sums that are due and payable at the time of service. No oral agreements have been made and this agreement . cannot be modified orally.
3. In the event that I direct medical claims to any insurance company other than my current general medical insurance provider
   including but not limited to workers compensation and auto insurance;
   a. I further agree to be bound by the financial Policy Addendum, attached hereto; and
   b. I shall direct payments from insurance to be made directly and solely to Keil Urogynecology and shall not allow any third party to retain sums owed to Keil Urogynecology.

4. I, the patient authorize payment for services made directly to Keil Urogynecology, which may otherwise be payable to me from all sources including medical insurance, workers compensation or other parties for medical benefits with whom I have contracted. Such benefits will not exceed Keil

Urogynecology's billed charges. I hereby accept full responsibility for providing Keil Urogynecology accurate and complete information needed for their assisting me in processing my claims for reimbursement. I authorize the refund of overpaid Insurance benefits where my coverage is subject to coordination of benefits. .

5. I agree to pay interest at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs

And reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to

50% of the outstanding balance.

Patient Printed Name_____
Date_____
Patient Signature_____
Updated 1/15/16