Aimee Nguyen, M.D.
North Dallas Urogynecology

GENERAL OFFICE POLICIES:

Appointments: Patients are seen by appointment only. We try our best to run on time. Therefore, if you are more than 15 minutes late, it is up to the discretion of the doctor whether we will be able to see you at your time slot. You may be asked to reschedule.

We call one to two days in advance for appointment reminders. This allows us to see all the patients who have requested appointment times that day. Thus, we do request that you cancel your appointment 24 hours in advance, or you may be billed.

Office Hours: Our office hours are 8:30 A.M. to 4:30 P.M. Monday through Friday, and we are closed from noon to 1pm for lunch. Dr. Nguyen or a covering physician is available 24 hours a day for urgent situations.

TREATMENT:

Medication: We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a very high co-pay, we would need to be provided with alternatives that are financially acceptable to you.
Refills: Please plan ahead for your prescription refills. If your prescription says no refills, please call your pharmacy. They will process an electronic or fax request to us. We need at least 24 hours notice to process the authorization.

MEDICAL RECORDS AND FORMS:

Our office follows the rules set forth by the Texas Medical Board when preparing and furnishing medical records. A $25.00 charge for the first twenty pages and $.50 per page for every copy thereafter is what they consider to be a reasonable fee. This fee includes the cost of copying and postage. Payment must be made prior to the release of the records. We ask that you allow 15 business days to process this from the date of the written request.
Copies of diagnostic tests or immunization records only will be provided at no charge with 48 hours notice.
If you require a form or a letter to be completed by the physician (other than excuse notes), a 48 hours notice is required. There will be a $25.00 charge for this service. Thank you for choosing Dr. Robert Najera, M.D. Please let the receptionist know if you would like a copy of this for your records.

_____

Patient Name (please print)

_____ _____

Patient/Legal Guardian Signature Date

PATIENT TESTIMONIAL CONSENT

By signing below, you are consenting to North Dallas Urogynecology use and disclosure of the information in your testimonial and acknowledgement that the testimonial and acknowledgement that the testimonial may be used, all or in part, in our advertising, publications, website, etc. Both now and in the future.

_____

Patient Name (please print)

_____ _____

Patient/Legal Guardian Signature Date

HIPAA Disclosure

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in your medical record at Texas Elite Plastic Surgery or may be received from outside health entities and filed in your medical record. I understand that this information can and will be used by North Dallas Urogynecology to (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly (b) Obtain payment from third-party payers (c) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 3140 Legacy Drive Suite 210, TX 75034. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature _____Date_____

Release of Information Authorization

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: ___ Yes ____ No
Release of Information to Spouse: ___ Yes ____ No
Spouse's Name: _____

Release of Information to Other Individual: ___ Yes ____ No
Name & Relationship: _____
Phone #: _____

Aimee Nguyen, M.D. North Dallas Urogynecology
Preferences

I prefer to be contacted in the following manner:

Phone#: ( ) _____

- ☐ Leave message with detailed information.
- ☐ Leave message with contact number only.
- ☐ Do **not** leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature _____Date_____
Patient/Guardian

Consent to receive text messages about appointment reminders:
Patients in our practice

I _____ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

- The **CELL PHONE NUMBER** that I authorize to receive
  - ☐ TEXT Reminders
    - Is: (_____) _____-_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

- ☐ I hereby revoke my request to receive any future appointment reminders for future communications via text.

Patient name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Aimee Nguyen, M.D.
PATIENT INFORMATION SHEET

Name	Date of birth	Age
Address	City State Zip	
Home Phone	Work Phone	Cell Phone
Social Security #	Marital Status: M S W D	
Ethnicity:	Language:	E-mail Address:

Emergency Information

Emergency Contact Name	Relationship	
Emergency Contact Home Phone	Work Phone	Cell Phone

Pharmacy Information

Pharmacy Name	**Address**	**Phone Number**

Patient Employer Information	Spouse's Information
Patient's Employer	Spouse's Name
Occupation	Spouse's Employer

Primary Insurance Information

Name of Primary Insurance	Insurance ID #
Subscriber's Name	Group #
Subscriber Date of birth	Co-Pay $ Prescription Plan: Yes No

Secondary Insurance Information

Name of Secondary Insurance	Insurance ID #
Subscriber's Name	Group #
Subscriber's Date of Birth	Co-Pay $ Prescription Plan: Yes No

Insurance Authorization and Assignment

I authorize North Dallas Urogynecology, PLLC to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for release services. I authorize the payment of all benefits to North Dallas Urogynecology, PLLC. I understand that I am ultimately responsible for all services whether covered by insurance or not. I authorize my physician, based on his/her discretion, to access my chart for utilization management review and to view my prescription history from external sources.

Date _____ Signature _____

North Dallas Urogynecology
Female Pelvic Medicine and Reconstructive Surgery

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Age:_____ Date: _____

Primary Care Physician:	Gynecologist:
Name: _	Name:
Address: _	Address: _
Phone:	Phone:

Name of previous Urologist (if applicable): _____

Whom may we thank for referring you to us? _____

Please describe in your own words the nature of your problems':

When did you first become aware of the problem? _____

Describe any previous treatments (medicines, surgery, etc.) prior to this visit:_____

Allergies: Do you have any drug allergies? Y N
If yes, please include name of drug or x-ray dyes and **describe the type of allergic reaction**:

Medical History: Height: _____ Weight: _____

As an Adult have you had (please circle):

Heart Disease High Cholesterol Reflux/GERD Depression
High Blood Pressure Stomach Ulcers Seizure disorder Anxiety Disorder Diabetes
Kidney Disease Paralysis Psychiatric Illness Anemia Liver
Disease Hepatitis B/C Glaucoma
Thyroid Disease Kidney/Bladder stones B a c k Problems Serious injury/Accident
Blood clots Bleeding problems Multiple Sclerosis Parkinson's disease
Stroke or TIAs Heart Attack Frequent Bladder Infections Abnormal pap smears
Chronic cough Asthma Emphysema/COPD HIV Congestive Heart Failure
Cancer, if yes, what type_____what type of treatment:_____ List other medical
conditions not listed above:_____

Surgical History

Have you had a hysterectomy? Y/N

*If yes…For what reason?*_____

…at what age?

What type of incision? Abdominal ____ *Vaginal*____ *Laparoscopic*____

Have you had your ovaries removed? Y N

Have you had any surgeries for incontinence or bladder problems? Y N

*If yes…what type and what age?*_____

Please list any other operations you've had and your age at the time:

_____

_____

_____

Family& Social History

Have any first degree relatives had these diseases? If so, please indicate their relationship to you.

High blood pressure _____ Heart Disease _____

Stroke _____ Diabetes _____

Cancer (please list type) _____ Kidney Disease _____

Breast Cancer _____ Osteoporosis _____

Blood/Clotting Disorder _____ Relaxation of Uterus or Vagina _____

Ovarian Cancer _____ Urinary Incontinence _____

Other family or Hereditary Diseases _____

Are you a: current smoker vape former smoker ☐ non- smoker ☐

If yes…how many packs per day _____ How many years?_____

Do you drink alcohol? Y N

If yes…how many drinks per week_____

Do you use recreational drugs? Y N

Your occupation_____

Current marital status (circle one): Single Married Divorced Widowed

Number of pregnancies _____ Number of Children _____

Number of miscarriages _____ Number of abortions _____

Date of Last Menstrual Period:_____

Last Pap Smear Date: Normal? Y N

Medications: Please list all current medications (including hormones, contraceptives, vitamin, and dosages)

Medication	Dosage	Frequency

Symptoms Review: Please circle any symptoms you've had in the past few months:

General Symptoms
Fever/Chills
Change in appetite
Headache
Wt. loss/gain>10lbs.
Nausea/vomiting

Hematologic/Allergy
Clotting Problems
Swollen Glands
Hay fever
Prolonged bleeding
Easy bruising

Gastrointestinal
Abdominal pain
Diarrhea
Blood in stools
Indigestion
Constipation/Bloating

Cardiovascular
Chest pain
Shortness of Breath
Varicose Veins
Swelling of legs

Neurological
Memory Loss
Dizzy spells
Tingling
Numbness
Insomnia
Tremors
Loss balance

Endocrine
Excessive thirst
Intolerance to hot/cold
Excessive fatigue

Musculoskeletal
Joint pain
Back pain
Weakness

ENT
Hearing Loss
Visual change
Cold
Cough
Sore throat
Blurred vision
Dry Eyes
History of glaucoma

Skin
Skin Rash/Boils
Change in-
Appearance of mole
Change in size of mole

Respiratory
Wheezing
Frequent cough
Cough up blood
Trouble breathing

Gynecologic
Breast pain or lump
Hot flashes
Vaginal Bleeding
Vaginal discharge

Psychiatric
Depressive symptoms
Thoughts of suicide
Anxiety
High Stress level
Difficulty Remembering

While answering these questions, please consider your symptoms over the last 3 months. We realize that you may not be having problems in some of these areas.

Do you experience, and, if so, how much are you bothered by…..	*Not at all*	*Somewhat*	*Moderately*	*Quite a bit*
Usually experience pain in the lower abdomen or Genital region?				
Usually experience heaviness or pressure in the pelvic				
Usually have a bulge or something falling out that you can see or feel in the vaginal area?				
Usually experience a feeling of incomplete bladder Emptying?				
Feel you need to strain too hard to have a bowel Movement? Constipation?				
Feel you have not completely emptied your bowel at the end of a bowel movement?				
Ever have to push on the vagina or around the rectum				
Usually lose stool beyond your control, if your stool is well formed or loose?				

1) Do you leak urine with activities such as: coughing gently/hard, sneezing, laughing, lifting, bending, jumping, and jogging or exercise?
   - If yes, how often? #Times____/day or # times'____/week. For how many years? ____
     i. Please circle which activities above that this occurs with.
     ii. Is this socially bothersome? Yes or No

2) When you get the urge to urinate, you might lose urine before you get to the toilet in time? Yes or No
   - If yes, how often? #Times____/day or # times_____/week. For how many years? ____
     i. Is this socially bothersome? Yes or No

3) How often do you typically get the urge to urinate on average?
   - _____ Every 30m – 1hr _____ Every 1hr – 2hr
   - _____ Every 2hr – 3hr _____ Every 3hr – 4hr
     i. Is this socially bothersome? Yes or No

4) How often do you wake up at night to urinate?____
   - Do you wake up at night due to urge or are you a light sleeper?

5) Do you leak urine without any warning or movement at all? Yes or No
   - If yes, how often? # Times____/day or # time's _____/wks.

6) Do you ever wet your bed at night when sleeping? Yes or No
   - If yes, how often? # Times_____/day or # time's_____/wks.

Labiaplasty

Are you dissatisfied with the appearance of your labia due to length, pigmentation, size, or asymmetry? Yes or No

Vaginal Rejuvenation

Does your vagina feel loose with minimal muscle tone? Yes or No

: _____

TELEHEALTH AUTHORIZATION AND RELEASE

I hereby consent to communicating by cell, e-mail and online with Dr. _____ and his/her staff and personnel (hereinafter referred to collectively as "my Doctor") so as to conduct virtual consultations, telemedicine/telehealth, and any other purpose deemed by my Doctor to be appropriate while I am receiving medical and aesthetic services.

As announced by the US Department of Health & Human Services ("HHS") on March 17, 2020, I understand my Doctor is now authorized to use non-public facing audio and/or video communication technology to provide telehealth, whether or not related to COVID-19, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, but my Doctor is not authorized to use public facing technology, such as Facebook Live, Twitch or TikTok. I accept that even authorized non-public facing third-party applications potentially introduce privacy risks, but my Doctor will enable all available encryption and privacy modes when using these applications.

I also agree that my Doctor may communicate with me by the following additional methods:

Cell # (calls and texts) (_____)_____ E-mail _____

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. Unless and until I revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from any telehealth medical privacy claims I might otherwise have had prior to HHS's March 17, 2020 notification. I certify that I have read this Authorization and Release and fully understand its terms.

_____ _____

Patient Signature *Witness/Physician/Staff*

_____ _____

Patient Name Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

_____ _____

Parent/Guardian/Conservator Signature Date

_____

Parent/Guardian/Conservator Name

AUTHORIZATION FOR THE RELEASE OF CONFIDENTAL PATIENT INFORMATION IN A MANNER CONSIDERED NON-HIPAA COMPLIANT

You have asked that we provide confidential patient data to you. HIPAA and the Department of Health and Human Services provide practices with guidelines that can be followed as "best practices" related to how this information can be transmitted.

You have requested that information be provided in a specific manner and/or to a specific location. While we are happy to accommodate your request, we must advise you that the transmittal you have requested is what we would consider as non-HIPAA compliant. Furthermore, once your patient information leaves our system and control, we cannot guarantee the security and confidentiality of this transmission. If your e-mail or fax is to a family e-mail address or fax number, shared e-mail or fax or corporate/employer/business e-mail address or fax number, others may see your information. Because of the many internet, e-mail or transmission factors beyond our control, we cannot be responsible for misaddressed, misdelivered, interrupted or intercepted transmissions. Yor health care provider is not liable for breaches of confidentiality caused by transmissions sent in an unsecured manner, or to an unsecured location/address that may be accessed by a third party.

Therefore, we ask that you sign this release acknowledging your acceptance of this risk and explicitly authorizing us to send your data as you request.

_____

Signature of Patient or Authorized Person Representative

_____ _____

Printed Name of Patient or Authorized Personal Representative Date

North Dallas Urogynecology_____

Name of Practice

_____

Received by Practice Representative