HOLLY KAY WYNESKI, MD
FEMALE UROLOGY

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of Parent or Guardian (If patient is a minor) _____

Alternative Address for mailing (optional) _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Preferred Contact Number: ___Home ___Cell ___Other Number _____

DOB: ____/____/_____ Social Security #: _____ Marital Status: _____

Employer _____ Occupation _____

Primary Care Doctor_____ Phone: _____ Fax_____

Referred by _____ (If doctor) – Phone _____ Fax_____

Reason for visit: _____

May we leave a message at your home with other residents? ___Yes ____No

If you have an answering machine or voicemail, may we leave a message? ___ Yes ___ No

If you want your mail sent to an alternate address:

_____

Who may we talk to about your medical concerns: _____

Relationship: _____ Home Phone _____ Work phone _____

Notify in Case of Emergency:

Last Name: _____First _____ Relationship _____

Home phone _____ Phone #2 _____

Notice: Holly Kay Wyneski MD, Female Urology, does not recognize Advanced Directives, DNA (Do Not Resuscitate), and will use all measures possible to sustain life. Resuscitative efforts will be implemented on a patient experiencing a life-threatening only while in the offices of Holly Kay Wyneski MD.

Payment Authorization/General Consent for Treatment

Medicare and Medicaid: I authorize the release of any medical or other information needed to process any claims on my behalf. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Holly Kay Wyneski MD, LLC for services rendered.

All other Insurance Companies and/or Third Party Payers: I HEREBY AUTHORIZE, Holly Kay Wyneski MD., LLC and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician and other health care professionals and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Holly Kay Wyneski MD., LLC for rendering services. I authorize the release of any medical or other necessary information to my insurance carrier or its intermediaries regarding services rendered.

Guarantee of Payment: I understand that filing a claim with my insurance company or other third party payers, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Holly Kay Wyneski MD., LLC to me or the patient as indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation and/or claims due to personal injury, accident/illness.

General Consent to Treatment: Having come to Holly Kay Wyneski MD. LLC for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize the Physician and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment and I understand that I have the right to refuse any suggested examination, test, or treatment.

Right to refuse treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____

Signature DATE

Holly Kay Wyneski, M.D.
128 E. Milltown Rd., Ste 205
Wooster, Ohio 44691

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of out Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice HAS A Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree with those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that she has received a copy of out HIPPA practices.

This Consent was signed by: _____

Printed Name/Date: _____

Relationship to Patient: _____

This Consent was refused by: _____

Printed Name/Date: _____

Relationship to Patient: _____

Witness: _____

Printed Name/Practice Respresentive: _____

HOLLY KAY WYNESKI, MD
FEMALE UROLOGY

FINANCIAL POLICY

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

We are committed to providing you with the best possible care. We are anxious to help you receive your maximum allowable benefits if you have medical insurance. In order to do this, we need your assistance and your understanding of our **FINANCIAL POLICY**. We will also be asking you to periodically update your information.

Payment for services is **DUE AT THE TIME SERVICES ARE RENDERED**, unless payment arrangements have been approved in advance by our office manager. **We accept CASH, CHECKS, MASTERCARD, VISA, and DISCOVER**. Returned checks are subject to a $30.00 NSF FEE. Non-payment of returned checks may result in your termination as a patient of Holly Kay Wyneski, MD.

If there is a divorce involved, please remember that our policy requires that regardless of which parent is responsible for the bills, **PAYMENT IS DUE AT THE TIME OF SERVICE**. The person that brings the child to the office for the appointment is expected to make payment. As you should be able to understand, we will not get involved with divorce disputes. Please feel free to discuss this with our office manager if you have any questions.

Auto accident claims will either be paid at the time of service or be billed through your medical insurance coverage.

We will submit your insurance forms for you with a current signature on file permitting us to do so. Please remember that:

1. Your insurance is a contract between YOU, YOUR EMPLOYER, and the insurance company. We are not a party to that contract.
2. Not ALL services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will NOT cover.

We must emphasize that as a provider of medical services, our relationship is to YOU, not your insurance company. While the filing of patient insurance forms is a courtesy we extend to our patients, all charges are YOUR responsibility from the date the service is rendered.

We are not providers for Workers' Comp care, and do not do any type of Workers' Comp paperwork or billing.

We realize that temporary financial problems may affect your timely payment of your account. If such problems DO arise, we encourage you to contact us promptly for assistance in the management of your account.

Patient Signature:_____ Date:_____

Medical History Questionnaire

Name:_____ Date of Birth:_____Date:_____

Personal Medical History

Problems:	YES	NO
Hyperthyroid		
Hypothyroid		
Asthma		
Anemia		
Blood Clot in Leg		
Blood Clot in Lungs		
Heart Attack **When?**		
Heart Murmur		
Coronary Artery Bypass		
AFib		
Hypertension		
Type 1 Diabetes		
Type 2 Diabetes		
Stroke		
Seizures		
Epilepsy		
Migraines		
Pelvic Fracture		
Lower Back Fracture		
Upper Back Fracture		
Neck Fracture		
IBS		
Diverticulitis		
Diarrhea		
Constipation		
Blood Clotting Disorder		
Kidney Stone **When?**		
UTI (Bladder Infection)		
Breast Cancer		
Uterine Cancer		
Ovary Cancer		
Lichen Sclerosis		
Vaginal Prolapse		
Multiple Sclerosis		
Hepatitis		
Sexually Transmitted Diseases		

Medications (Include all Vitamins and Herbal Supplements)

Where would you like us to send your medications?

Locally_____City:_____

Mail Order _____

Allergies?_____

Current Social History

Do you Smoke? YES or NO

Have you Ever Smoked? YES or NO (If Yes when did you Quit?_____)

Do you drink Alcohol? YES or NO (If Yes, How Often? Daily, Weekly, Monthly, Socially)

Do you feel Safe at Home? YES or NO (If NO, would you like us to help you contact law enforcement?)

Previous Surgery:

Vaginal Surgery? YES or NO (If Yes, Please Explain:_____)

Hysterectomy? YES or NO (If Yes, Please Explain:_____)

Ovary(s) Removed? YES or NO If Yes, Please Explain:_____)

Kidney Surgery ? YES or NO (If Yes, Please Explain:_____)

Kidney Stones? YES or NO? (If Yes, Please Explain:_____)

Bladder Surgery? YES or NO?(If Yes, Please Explain:_____)

Other Surgery?

_____

_____

_____

Family History

Breast Cancer? YES or NO (If YES then who?_____)

Colon Cancer? YES or NO (If YES then who?_____)

Ovarian Cancer? YES or NO (If YES then who?_____)

Uterine Cancer? YES or NO (If YES then who?_____)

Other Cancer? YES or NO (If YES then who?_____)

Blood Clots in Legs? YES or NO (If YES then who?_____)

Blood Clots in Lungs? YES or NO (If YES then who?_____)

Miscarriages? YES or NO (If YES then who?_____)

Diabetes? YES or NO (If YES then who?_____)

Heart Disease? YES or NO (If YES then who?_____)

Endometriosis? YES or NO (If YES then who?_____)

Infertility? YES or NO (If YES then who?_____)

Bleeding Disorders? YES or NO (If YES then who?_____)

Cystic Fibrosis? YES or NO (If YES then who?_____)

Stroke? YES or NO (If YES then who?_____)

Hypertension? YES or NO (If YES then who?_____)

Overactive Bladder Questions

Do you have Overactive Bladder? YES or NO

What medication do you currently take?_____

What medications have you taken in the past?

____Oxybutynin/Ditropan ____Detrol LA/Tolterodine ____Sanctura/Trospium

____Vesicare/Solifenacin ____Mybetriq/Mirabegron ____Toviaz/Fesoterodine

Have you ever taken any Medication with ESTROGEN in it? EX: Pills or Vaginal Cream YES or NO

If Yes please tell us the name of the cream/pill._____