

Dear Valued Patient,

Drs. Nicolette Horbach, Jeffrey Welgoss and Walter von Pechmann are pleased to announce, as of January 13, 2015, our practice Mid Atlantic Urogynecology and Pelvic Surgery has joined Privia Medical Group (PMG), a multi-specialty group of top physicians in our area. Privia Medical Group is dedicated to providing better, more coordinated care to patients and our decision to join reflects our commitment to provide you with the highest level of care.

We will continue to manage and run our own practice, under the umbrella of PMG. Our practice location, contact information, and staff will remain the same.

As part of Privia Medical Group, we are proud to offer a patient portal that gives you convenient, 24-hour access to your personal health information. The patient portal allows you to:

- Access your lab results
- Request prescription refills
- Send and receive secure messages with your physician
- Check in for your appointments in advance
- Receive reminders on important overdue tests
- Pay your bill and view your bill history
- Receive alerts and updates from your physician

Here is how you access the portal:

You will receive an invitation email with a link to join the portal. Click on **REGISTER** which will take you to another screen to **Verify Your Identity** by calling your primary phone number and giving you a PIN Code. Once you click Send Code the system will call your number and provide you with a PIN Code. Use this PIN Code to create your account and set up your password. Once you are logged in you will see your appointment date, time and provider at the top. Under that you will see a form: Urogynecology Patient History, *please fill it in completely... But you may skip the Vaccines section if you cannot remember the exact dates.* We ask that you also please complete the MY PROFILE tab on the left. To ensure a smoother appointment process please complete both the Urogynecology Patient History and the entire My Profile section prior to your appointment day and time.

Our practice will continue to accept a wide variety of insurance plans. Our goal is to make the transition as smooth as possible for you, and to continue to provide you with the same high standard of care you have come to know and deserve.

PLEASE DO NOT RESPOND TO THIS EMAIL

Thank you.



Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Privia, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in the Privia network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of services provided to me by Privia and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent to Treatment

As a Privia patient, I voluntarily consent to the rendering of such care and treatment as the Privia providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Privia provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that Privia may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Privia.

I understand that I may voluntarily "opt-in" to receive automated text message communications from Privia and its partners by informing my provider's staff or visiting "My Profile" on my Privia Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received Privia's Financial Policy and Notice of Privacy Practices. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Privia providers.

Printed Name of Patient: _____ **Date:** _____

Signature: _____

Email: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

***Note: If patient declines to participate in HIE, patient must follow the appropriate procedure outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.**

ADDENDUM TO FINANCIAL POLICY REGARDING
SURGERIES

PLEASE NOTE:

Surgeries cancelled less than two weeks before the surgery date will be charged \$350.00, unless cancelling the surgery is due to other medical reasons.

ACKNOWLEDGED BY PATIENT:

PATIENT NAME

PATIENT DATE OF BIRTH

PATIENT SIGNATURE

DATE

MID ATLANTIC UROGYNECOLOGY AND PELVIC SURGERY
RELEASE OF PATIENT INFORMATION CONSENT FORM

PATIENTS NAME: _____ DATE: _____

PATIENTS DOB: _____ SOCIAL SECURITY: _____

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION (IF NONE – PLEASE WRITE NONE – THANK YOU)

Referring Physician: _____ Primary Care: _____

Gynecologist: _____ Cardiologist: _____

Other: _____

RELEASE INFORMATION TO VOICE MAIL

In the event we are unable to speak to you directly may we leave a message on your voice mail regarding test/lab results, post op response/instructions or prescription information?

Please circle yes or no.

Yes please provide us with the phone number(s).

No please do not put in any phone number(s).

1. _____ 2. _____ 3. _____

RELEASE INFORMATION TO FAMILY/FRIENDS

You have my permission to contact the following individual(s) listed below for whom I designate to be informed of my medical care.

1. _____	At _____	Relationship: _____
2. _____	At _____	Relationship: _____
3. _____	At _____	Relationship: _____
4. _____	At _____	Relationship: _____

(I AM FULLY AWARE THAT A CELLULAR PHONE IS NOT A SECURE AND PRIVATE LINE.)**

RELEASE OF INFORMATION TO/FROM OUTSIDE PHYSICIANS

You have my permission to send/receive medical information to/from the following physicians if needed.

Please provide **both first & last name of each physician, phone number and specialty.**

DOCTOR'S FULL NAME	PHONE	SPECIALTY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELEASE INFORMATION TO PHARMACY

You have my permission to send any prescriptions needed to the pharmacy listed below.

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

(I AM FULLY AWARE MY HEALTH INFORMATION WILL BE TRANSMITTED BY ELECTRONIC TRANSMISSION, FAX TRANSMITTAL, INTERNET, OR EMAIL.)**

(Patient Signature) (Date)

(Witness Signature) (Date)

MID ATLANTIC UROGYNECOLOGY AND PELVIC SURGERY

UROGYNECOLOGY SYMPTOM QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Please circle or describe the issues you would like to be evaluated for today:

Pelvic organ prolapse (uterine prolapse, cystocele, rectocele, enterocele, rectal prolapse)

Vaginal pressure or bulging

Pain during intercourse

Bladder control problems

Hysterectomy

Difficulty urinating

Fibroids

Bowel problems

Heavy menstrual periods

Other: _____

Are you considering surgery to treat your problem?

Yes

No

Maybe, but I need more information

BLADDER SYMPTOMS	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>
Do you leak urine?				
Do you leak urine with coughing, sneezing, or activity?				
Do you experience urine leakage when you have the urge to urinate?				
Do you have urinary urgency or void more frequently than every 2 hours?				
Do you wake up two or more times at night to urinate?				
Do you experience trouble urinating or completely emptying your bladder?				
How often are you bothered by bladder symptoms?				

BLADDER HISTORY	<i>Yes</i>	<i>No</i>
Have you tried Kegel exercises to improve bladder control?		
Have you taken any medications to improve bladder control?		
Have you ever had surgery to improve bladder control?		
Do you have three or more urinary tract infections per year?		
Do you see or have you been told that you have blood in your urine?		

Please describe any tests or treatments you have undergone for bladder control problems:

MID ATLANTIC UROGYNECOLOGY AND PELVIC SURGERY

Patient Name: _____

Date of Birth: _____

PROLAPSE SYMPTOMS	Never	Rarely	Sometimes	Often
Do you ever see or feel a bulge at the opening of the vagina?				
Do you ever see or feel tissue bulging beyond the opening to the vagina?				
Do you experience pelvic/vaginal pressure or heaviness?				
Do you ever have to push a bulge in during urination?				
Do you ever have to push a bulge in during bowel movements?				
How often are you bothered by prolapse symptoms?				

Please describe any tests or treatments you have undergone for pelvic organ prolapse:

BOWEL SYMPTOMS	Never	Rarely	Sometimes	Often
How often do you have irregular bowel movements (<2/week)?				
Do you feel the need to strain excessively during bowel movements?				
Do you feel that you have not emptied your bowel at the end of a bowel movement?				
Do you ever lose stool beyond your control if your stool is well formed?				
Do you ever lose stool beyond your control if your stool is loose?				
Does part of your rectum ever pass through the anus and bulge outside during or after a bowel movement?				
How often are you bothered by bowel symptoms?				

Please describe any tests or treatments you have undergone for your bowel problems:

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Please circle if you **CURRENTLY** have any of the following:

Constitutional

fever, chills, weight gain (___ lbs), weight loss (___ lbs), fatigue, exercise intolerance, diminished activity, loss of appetite, sleep problems, change in ADL's (ability to do everyday activities), night sweats

Eyes

vision change, eye pain, photophobia (sensitivity to light), eye watering/discharge, eye redness, eye irritation, eye itchiness, dry eyes, swelling around eyes, abnormal eye movement

Cardiovascular

chest pain, arm pain on exertion, exertional dyspnea (shortness of breath with activity), orthopnea (shortness of breath when lying flat), palpitations, known heart murmur, edema, orthostatic symptoms (dizziness)

Respiratory

difficulty breathing, shortness of breath, cough, wheezing, chest congestion, pain with respiration, coughing up blood, coughing up sputum, sleep apnea, paroxysmal nocturnal dyspnea (shortness of breath and/or coughing when lying down), rapid breathing

Musculoskeletal

arthralgias (joint pain), joint swelling, joint stiffness, back pain, history of fractures, bone pain, limb pain, limb swelling, bony mass, myalgias (muscle pain), muscle weakness, muscle cramps, muscle spasms

Integumentary

abnormal mole skin lesion, skin growth, rash, jaundice, dry skin, skin color changes, skin texture changes, skin cracking, photosensitivity (sensitivity to light), nail symptoms, fingernail thickening, toenail thickening, nail pitting, brittle nails, nail yellowing

Breast

pain, lump, nipple discharge, itching, redness, swelling, skin changes, skin dimpling

Neurologic

loss of consciousness, headaches, weakness, numbness, dizziness, lightheadedness, seizures, restless legs symptoms, memory lapses or loss, confusion or disorientation, decreased concentrating ability, episodes of being lost, involuntary movements, decreased coordination

Hematologic/Lymphatic

lymphadenopathy (swollen lymph nodes), easy bruising, easy bleeding tendency

Allergic/Immunologic

anaphylactic reactions, allergic reactions, rhinitis (runny nose), frequent sneezing, seasonal allergies, food allergies, pruritis (itching), urticaria (hives)

