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
- Schedule your appointments online
- 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.

Thank you.

Mid-Atlantic Urogynecology and Pelvic Surgery

3289 Woodburn Road Suite 130 Annandale, VA 22003 **110 Hospital Road, Suite 203 Prince Frederick, MD 20678**

PRIVIA
MEDICAL GROUP

Patient Information

Last Name ______
First Name ______
Middle Name ______
Former Last Name ______
Sex ______
DOB ______
SSN ______
Address ______
Address 2 ______
Zip ______
City ______
State ______
Home phone ______
Mobile phone ______
Work phone ______
Email (required) ______
Preferred Pharmacy ______
Contact preference (please circle): HOME MOBILE WORK
Language ______
Race ______
Ethnicity ______
Marital Status ______
Homebound? YES NO
How did you hear about us? **(please circle options below)**

Advertising Primary Care Physician Specialist Physician Word of Mouth

Insurance Patient in Practice Hospital Insurance Co. Other

Specify (if Other, above) ______

Today's Date ______

Guardian

Last Name ______
First Name ______
Middle name ______

Emergency Contact

Name ______
Relationship ______
Home phone ______
Mobile phone ______

Next of Kin

Name ______
Relationship ______
Phone ______

Employment

Employer name ______
Employer phone ______

Guarantor Information

Last Name ______
First Name ______
Middle name ______
DOB ______
Address ______
Address 2 ______
Zip ______
City ______
State ______

Optional Information

Phone ______

Primary Insurance Information

Insurance Plan Name ______________________

ID/Certification No. ______________________

Policy/Group No. ______________________

Secondary Insurance Information

Insurance Plan Name ______________________

ID/Certification No. ______________________

Policy/Group No. ______________________

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: ______________________

Last Name ______________________

First Name ______________________

Middle Name ______________________

Address ______________________

Address (ctd) ______________________

City ______________________

State ______________________

Zip ______________________

Date of Birth ______________________

Policy Holder Sex ______________________

Employer Name ______________________

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: ______________________

Last Name ______________________

First Name ______________________

Middle Name ______________________

Address ______________________

Address (ctd) ______________________

City ______________________

State ______________________

Zip ______________________

Date of Birth ______________________

Policy Holder Sex ______________________

Employer Name ______________________

Patient Signature: ______________________ **Date:** ____________

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)

PATIENT QUESTIONNAIRE

Patient Name: ______________________ **DOB:** _________________ **Today's Date:** ________

Please complete the following:

YOUR MEDICATIONS

Medications (Names and Dosages)

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Drug Allergies and Reaction:

____
____
____
____
____
____
____
____
____
____
____
____
____

Latex Allergy ____________________________

Iodine Allergy ___________________________

GYN HISTORY

Age at Onset of Menstrual Period________________

Period comes every ______days

Duration of Flow (days)_________________________

Flow (circle one) Light Moderate Heavy

If Post Menopausal, Age at Menopause____________

Date of Last Pap Smear________________________

Abnormal Pap_______________________________

If Prior Abnormal Pap, Treatment Received_________

Date of Last Pelvic Exam_______________________

Date of Last Mammogram_______________________

Sexually Active Y ☐ N ☐

Current Birth Control Method (circle one)

None Condoms Birth Control Pills IUD Vaginal Ring

Tubal Ligation Essure Seeking Pregnancy

Pain With Intercourse Y ☐ N ☐

Sexually Transmitted Diseases__________________

OB HISTORY

Total Number of Pregnancies ___________________

Number of Vaginal Deliveries ___________________

Weight of Largest Baby _______________________

Number of Cesarean Sections __________________

Number of Ectopic Pregnancies_________________

Are you still considering further childbearing? ______

FAMILY HISTORY (please specify parent, sibling or child)

Blood coagulation disorder ____________________

Cancer: Breast _____________ Cervix _________

Ovary _____________ Uterus _________

Other cancer (specify) ________________________

Diabetes __________________________________

Heart disease ______________________________

Heart attack _______________________________

Stroke ____________________________________

SOCIAL HISTORY

Smoking History: Never Former Current

Years of Use _______________________________

Packs Per Day ______________________________

Alcohol ___________________________________

Caffeine __________________________________

Drugs ____________________________________

Marital Status ______________________________

Occupation_________________________________

Living Situation (independent, assisted, etc.)

____

MEDICAL HISTORY

Patient Name: ______________________ **DOB:** _________________ **Today's Date:** ________

Please circle if you have/had any of the following and provide date that the condition occurred or began

No significant past medical history
Abuse / Domestic Violence
Allergies (environmental/food) ___________________
Anemia ______________________________
Anesthesia Complications ___________________
Anxiety Disorder ___________________________
Arrhythmia ______________________________
Arthritis ________________________________
Asthma _________________________________
Bi-Polar ________________________________
Bleeding Disorder ___________________________
Blood Clots/DVT/Pulmonary Embolism _____________
Bronchitis _______________________________
Cancer _________________________________
Cardiovascular Disease ______________________
Cerebrovascular Accident (Stroke) _______________
Chronic Obstructive Pulmonary Disease (COPD) _______
Colon Polyp ______________________________
Congestive Heart Failure (CHF) ________________
Coronary Artery Disease _____________________
Depression ______________________________
Dermatologic Disorder _______________________
Diabetes Mellitus ___________________________
Diverticulosis ______________________________
Endocrine Disorder ___________________________
Fibromyalgia ________________________________
Gastroesophageal Reflux Disease (GERD) ___________
Genetic / Hereditary Disorder ___________________

HIV or AIDS ______________________________
Head Injury ______________________________
Heart Murmur _____________________________
Hematologic Disease ________________________
Hepatic / Liver Disease _______________________
Hepatitis _________________________________
Hypercholesterolemia ________________________
Hypertension ______________________________
IBS _____________________________________
Immunologic Disorder ________________________
Meniere's disease __________________________
Migraines ________________________________
Musculoskeletal Disease ______________________
Myocardial Infarction (heart attack) _____________
Nasal polyps ______________________________
Neurologic Disorder _________________________
Obesity __________________________________
Osteoporosis ______________________________
Pneumonia ________________________________
Psychiatric Illness __________________________
Pulmonary / Lung Disease ____________________
Renal / Kidney Disease _______________________
Rheumatic Fever ___________________________
Seizures / Epilepsy _________________________
Other ___________________________________
____
____
____

SURGICAL HISTORY

Patient Name: ______________________ **DOB:** ________________ **Today's Date:** ________

Please indicate any surgeries (checkbox), the year that they were performed, and any additional information that you think might be important.

	YEAR PERFORMED	ADDITIONAL INFORMATION
☐ None		
☐ Abdominoplasty (tummy tuck)	____________	____________________________
☐ Appendectomy	____________	____________________________
☐ Back/Spine	____________	____________________________
☐ Breast	____________	____________________________
☐ Cesarean section	____________	____________________________
☐ Cardiac	____________	____________________________
☐ Cardiac stent	____________	____________________________
☐ Colorectal	____________	____________________________
☐ Endometriosis	____________	____________________________
☐ GI	____________	____________________________
☐ Hemorrhoid	____________	____________________________
☐ Hernia repair	____________	____________________________
☐ Hysterectomy	____________	____________________________
☐ Ovary/Fallopian tube	____________	____________________________
☐ Incontinence surgery	____________	____________________________
☐ Oncologic/Cancer	____________	____________________________
☐ Orthopedic	____________	____________________________
☐ Plastic/Reconstructive	____________	____________________________
☐ Prolapse	____________	____________________________
☐ Pulmonary/Lung	____________	____________________________
☐ Thoracic/Chest	____________	____________________________
☐ Tonsilectomy	____________	____________________________

MEANINGFUL USE/SCREENING QUESTIONS

Date of last Pap smear: ________________________

Date of last mammogram: ______________________

Date of last colonoscopy: _______________________

Date of Influenza immunization: __________________

Date of Pneumonia vaccination: __________________

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	***Never***	***Rarely***	***Sometimes***	***Often***
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	***Yes***	***No***
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 disoriention, 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)

Mid-Atlantic
Urogynecology & Pelvic Surgery

Nicolette Horbach, MD   Jeffrey Welgoss, MD   Walter von Pechmann, MD   Cindy Atkins, PA-C
Phone: 571.389.7140   Fax: 703.992.7584
www.urogyndocs.com

RELEASE OF MEDICAL RECORDS

I, ______________________________ ______________ ______________,
(Patient's Name) *(Date of Birth)* *(Social Security Number)*
Authorize the release of my medical records from:

Physician Name: ______________________________
Address: ______________________________
Phone: ______________________________
Fax: ______________________________

To: Dr. ____________________
Mid Atlantic Pelvic Surgery Associates
3289 Woodburn Rd. Ste 130
Annandale, VA 22003
Phone: 571-389-7140
Fax: 703-992-7584

Please release the following:
- All Records
- Pap Smears
- Pathology Reports
- Operative Notes
- Laboratory Reports
- Other: ______________________________

Patient Signature: ______________________________

Date: ______________________________

Witness: ______________________________