Michael Polin, MD
1930 Alcoa Hwy., Suite A-235
Knoxville, TN 37920
(P) (865) 305-5940
(F) (865) 305-5941

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Date: _____

Dear: _____

We would like to welcome you to University Urogynecology. We appreciate the trust you have placed in us. You are scheduled to see Dr. Michael Polin on _____ at _____ EST. Please arrive 30 minutes prior to your appointment to allow us to complete your registration. **If you should arrive 10 minutes after your scheduled appointment time listed above, you will be asked to reschedule to a later date!**

Enclosed is the new patient paperwork for your initial visit. **It is imperative that you return the completed packet in the provided pre-paid self-addressed stamped envelope immediately so that we can request the proper records prior to your appointment. Include the name of the physician, along with their contact information and dates pertaining to any surgeries, studies, or procedures related to your diagnosis.** We will require your current insurance card(s) and co-payment.

Parking is available in parking garage H and located across from the fountain circle. Campus parking is $2.00 and is paid as you exit the premises. Enclosed is a map to help you find the correct parking area. We are in Building A on the 2nd floor. We are located in Suite 235 across from the elevators. Please allow 15 minutes for commuting from the parking lot to our office.

If you have any questions, please contact us during our business hours Monday - Friday 8:00 am - 4:30 pm.

Thank you,

UT Urogynecology

UT UROGYNECOLOGY
PATIENT REGISTRATION

Date:	For Internal Use Only:	MRN:
PATIENT INFORMATION		
First Name:	Middle:	Last:
Social Security Number:		Date of Birth:
Home Address:		
City:	State:	Zip:
Home Phone:		Cell Phone:
Email Address:	Race:	Ethnicity:
Employment Status (Circle One):	Employed Retired Disabled Student Other	
Employer:		Work Phone:
Marital Status (Circle One):	Married Single Divorced Widowed	
Referring Physician:		Phone:
How Did You Hear About Our Office:		
PREFERRED PHARMACY		
Pharmacy Name:		Phone:
PRIMARY INSURANCE INFORMATION		
Insurance:	ID:	Group:
Name of Insured:	DOB:	SSN:
SECONDARY INSURANCE INFORMATION		
Insurance:	ID:	Group:
Name of Insured:	DOB:	SSN:
EMERGENCY CONTACT (List TWO)		
First Name:	Middle:	Last:
Relationship:		
Home Phone:	Cell Phone:	Work Phone:
First Name:	Middle:	Last:
Relationship:		
Home Phone:	Cell Phone:	Work Phone:
SPOUSE/GUARANTOR/RESPONSIBLE PARTY		
First Name:	Middle:	Last:
Home Address:		
City:	State:	Zip:
Social Security Number:		Date of Birth:
Relationship:		
Employer:		
Employer Address:		
City:	State:	Zip:

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay any non-covered services.

SIGNATURE (Patient or Parent if minor) DATE

UT Urogynecology Insurance Payment Policy

Thank you for choosing UT Urogynecology. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross/Blue Shield, Blue Care, Champus-military only, Cigna, the Initial Group, Humana, Americhoice Tenncare, and United Health. We are **not** insured with UHC Secure Horizon. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up to date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.
2. **Co-payments.** All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.
3. **Non-Covered Services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit to your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.
5. **Claim submission.** We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. We will pre-collect any expected coinsurance or deductibles prior to scheduling surgeries and procedures. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any money's owed after we have received payment from Medicare and/or a secondary policy that you might have.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.
7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Partial payments are accepted as long as you call them directly to set up the necessary payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by all guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

Patient Privacy Questionnaire and Notification

Patient Name:_____ Date of Birth:_____

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at: _____Home #_____

_____Cell #_____

_____Work #_____

_____Other #_____

_____May ONLY leave information with me. (If you check here, no other choice should be marked).

_____May leave appointment reminders on my answering machine/voicemail.

_____May leave lab results on my answering machine/voicemail.

_____May leave general questions/information on my answering machine/voicemail.

_____May send confidential messages regarding appointments, lab results, or general messages to your patient portal account

_____May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:_____Relationship:_____

Name:_____Relationship:_____

_____May leave appointment reminders with the above listed person

_____May leave lab results with the above listed person

_____May leave general questions/information with the above listed person

_____May discuss billing information with the above listed person

_____I prefer that all healthcare messages be given to the above listed person

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

Signature of Patient_____ Date_____

UT UROGYNECOLOGY

C. Bryce Bowling, MD
Robert Elder, MD
Michael Polin, MD
Jessica Dove, FNP-BC

1930 Alcoa Hwy, Suite A-235
Knoxville, TN 37920
(P) 865-305-5940 (F) 865-305-5941

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

_____

I hereby authorize the release of medical records to UT Urogynecology for the purpose of Medical Treatment.

Records to be released from: _____

_____

_____

The authorization will expire on: _____.
(Date or Event may not exceed one year)

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment,
Condition or dates of treatment: _____

_____

_____ Specific records to be released (example: labs, imaging reports, operative reports):

_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance and thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient **Date**

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THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

PLEASE PROVIDE THE NAME, ADDRESS, AND OFFICE NUMBER OF YOUR PRIMARY CARE PHYSICIAN AND YOUR GYNECOLOGIST

PCP
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

GYNECOLOGIST
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Referring Physician: _____

Please list any other Physician's you would like to receive your records from UT Urogynecology:
_____ _____

Please describe, in your own words, the nature of your gynecologic or urologic problems: _____
_____

Do you leak urine when you cough, laugh, or sneeze? □ Yes □ No If yes, how often: _____
Do you leak urine upon standing or on your way to the bathroom? □ Yes □ No If yes, how often: _____
On a normal day, how often do you urinate (i.e. every 30 mins, every hour, every 2 hours, etc): _____
On a normal night, how many times do you wake up to urinate: _____
Mark all that apply: □ feeling of incomplete bladder emptying after urination □ urinary hesitancy □ strain to urinate
□ urine flow that starts and stops □ abnormal urine flow/stream □ pain with urination
How often do you have a bowel movement? _____
Do you accidentally lose control of stool or gas? □ Yes □ No If yes, how often: _____
Are you sexually active? □ Yes □ No If yes, do you have pain with intercourse? □ Yes □ No

ALLERGIES:
Do you have any drug allergies? □ Yes □ No
Please list the drugs that you are allergic to and what happens when you take them: _____
_____

MEDICAL HISTORY:
Have you had (please circle):

Heart Disease	Liver Disease	Syphilis	Glaucoma
High Blood Pressure	Anxiety Disorder	Venereal Warts	Back Problems
Diabetes	Depression	HIV/AIDS	Fibromyalgia
Anemia	Psychiatric Illness	Stroke	Kidney Disease
Thyroid Disease	Seizure Disorder	Parkinson's Disease	Interstitial Cystitis
Chronic Cough/Asthma	Abnormal Pap Smears	Multiple Sclerosis	Kidney/Bladder Stones
Pneumonia	Chlamydia	Paralysis	Blood in Urine
Reflux/GERD	Gonorrhea	Serious Injury/Accident	Frequent UTIs
Stomach/Duodenal Ulcers	Herpes	Blood Clots/DVT	Cancer

Type of Cancer: _____
Treatment Performed: _____
Other: _____

SURGICAL HISTORY:

Have you had a hysterectomy? □ Yes □ No If yes, for what reason? _____
What year was your hysterectomy done? _____
What type of hysterectomy/incision did you have? □ Abdominal □ Vaginal □ Laparoscopic or Robotic
Who performed the hysterectomy? _____ Which hospital was this performed in? _____

Have your ovaries been removed? □ Yes □ No

Have you had any surgeries for incontinence, prolapse, or other bladder problems? □ Yes □ No
If yes, what was done? _____ What year was the surgery done? _____
Who performed the surgery? _____ Which hospital was this performed in? _____

Please list any other surgeries that you have had in the past and when you had them: _____

_____

_____

FAMILY HISTORY:

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

High Blood Pressure _____ Diabetes _____
Stroke _____ Heart Disease _____
Breast Cancer _____ Kidney Disease _____
Ovarian Cancer _____ Osteoporosis _____
Cancer (please list type) _____ Relaxation of uterus or vagina _____
Blood Clotting Disorder _____ Urinary Incontinence _____
Other Family or Hereditary Disease _____

SOCIAL HISTORY:

Do you smoke? □ Yes □ No If yes, how many packs per day? _____ and for how many years? _____
Do you drink alcohol? □ Yes □ No If yes, how many drinks per week? _____
Occupation: _____ Spouse's Occupation (if married): _____
Current Marital Status: □ Married □ Single □ Divorced □ Widowed

OBSTETRIC/GYNECOLOGIC HISTORY:

Number of Children: _____ Number of vaginal deliveries: _____ Number of C-sections: _____
Number of Miscarriages or Abortions: _____
Have you been through menopause? □ Yes □ No
Do you use vaginal estrogen cream? □ Yes □ No Do you take estrogen pills by mouth? □ Yes □ No

SYMPTOM REVIEW: PLEASE CIRCLE ANY SYMPTOMS YOU'VE HAD IN THE PAST FEW MONTHS:

General Symptoms:
- Fever or Chills
- Change in Appetite
- Weight loss/Gain > 10 pounds
- Nausea/Vomiting

Neurological:
- Headache
- Tremors
- Dizzy Spells
- Numbness

Cardiovascular
- Chest Pain
- Shortness of Breath w/ Exertion
- Swelling of Legs

Eyes/Ear/Nose/Throat:
- Blurred Vision/Visual Changes
- Ear Infections/Pain
- Ringing in the Ears

Hematologic/Allergy:
- Clotting Problems
- Swollen Glands
- Prolonged Bleeding
- Easy Bruising

Endocrine:
- Excessive Thirst
- Intolerance to Hot/Cold
- Excessive Fatigue

Skin:
- Skin Rash
- Boils

Respiratory:
- Wheezing
- Frequent Cough
- Coughing Up Blood
- Trouble Breathing

Gastrointestinal:
- Abdominal Pain/Bloating
- Diarrhea
- Constipation
- Indigestion

Musculoskeletal:
- Joint Pain
- Back Pain
- Weakness

Gynecologic:
- Breast Pain/Lump
- Hot Flashes
- Vaginal Bleeding
- Vaginal Discharge

Psychiatric:
- Depressive Symptoms
- Anxiety
- Difficulty Remembering

Medication List

Patient Name:_____DOB_____

Allergies

Medication Name	Directions