# THEODORE BENDEREV, M.D.

CERTIFIED BY THE AMERICAN BOARD OF UROLOGY
IPSI- A Medical Corporation
26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
Phone 949-364-4400

Dear _____:

Thank you for choosing to schedule your appointment with Dr. Theodore Benderev for your vasectomy.

Enclosed please find the information packet necessary to complete your chart. In order to serve you in a timely manner, we ask that you **complete the information PRIOR** to your appointment and **bring** this information back with you at the time of your appointment. **Please do not mail these forms back to our office.** If your paperwork is incomplete or forgotten, you may arrive 30 minutes early to fill out paperwork or we will likely have to reschedule your appointment.

Please bring with you your insurance card and driver's license. Deductibles and co-payments are due and will be collected at the time of your visit. You will be responsible for payment at the time of service if you arrive without your insurance card. Your insurance is a contract between you and your carrier. Our staff will assist you to the best of their ability in dealing with your insurance company, but it is your responsibility to know and understand your insurance policy and coverage of your plan before you arrive for your visit. If you are choosing to use your Point of Service or Out of Network Options, we recommend that you contact your insurance carrier prior to coming to our office and notify them that you are using this option for our doctors.

We are located at 26732 Crown Valley Parkway (in the Mission Medical Tower) in Suite #327. Paid parking is available in the covered parking structure. Our office can be reached by turning at Los Altos off of Crown Valley Parkway. (See diagram below.) We do not validate parking. Please feel free to call us at (949) 364-4400 if you have any questions.

***Please remember to wear long pants and wear an athletic supporter (jock strap) or tight briefs when you arrive for your procedure. Make sure that you have a light meal on the morning of the procedure.***

Your appointment is on _____ at _____.

Thank you for choosing us for your vasectomy and we look forward to serving you.

Sincerely,

Theodore V. Benderev, M.D.

# THEODORE V. BENDEREV, M.D.

## PLEASE COMPLETE IN ITS ENTIRETY PATIENT INFORMATION SHEET

(All information is necessary to bill your insurance for you) DATE:_____

LEGAL NAME - FIRST:_____ LAST:_____ MI_____

DO YOU WISH TO BE ADDRESSED BY ANOTHER NAME? IF YES, INDICATE NAME:_____

STREET:_____ APT.#_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE # ( )_____ DRIVER'S LICENSE:_____ EXP. DATE:_____

IF WE CAN FAX AND/ OR E-MAIL MATERIAL TO YOU, PLEASE GIVE US YOUR FAX AND/ OR E-MAIL ADDRESS:

CELL#: ( ) _____ FAX# ( ) _____ E-MAIL _____

SOCIAL SECURITY: _____ DATE OF BIRTH: _____ SEX: F M

EMPLOYER: _____ POSITION: _____

EMPLOYER ADDRESS: _____

WORK PHONE # ( ) _____ MARRIED_____ SINGLE_____ DIVORCED_____ WIDOWED _____

YOUR PRIMARY CARE PHYSICIAN: _____ PHONE # ( )_____

WHO REFERRED YOU TO OUR OFFICE? DR. / MR. / MRS. / MS. _____

IF NOT REFERRED, HOW DID YOU FIND OUT ABOUT US? _____

### INSURANCE INFORMATION: (PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT)

IF YOU DO NOT HAVE PROOF OF INSURANCE, PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED.

MEDICARE # (IF APPLICABLE): _____

OTHER INSURANCE ID # _____ GROUP # _____ INSURANCE CO: _____

## RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)

FIRST NAME: _____ LAST: _____ MI:_____

SOCIAL SECURITY #_____ DATE OF BIRTH: _____

EMPLOYER: _____ DRIVER'S LICENSE # _____

RELATIONSHIP TO PATIENT: _____ SPOUSE'S NAME: _____ SPOUSE'S D.O.B._____

## IN CASE OF EMERGENCY:

NOTIFY: _____ PHONE # ( )_____

RELATIONSHIP TO PATIENT:_____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE DOCTOR WHOSE NAME APPEARS ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

I HAVE READ AND FULLY UNDERSTAND THE 'FINANCIAL POLICIES" BELOW. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A $5.00 MONTHLY FEE FOR BILLING SERVICE. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: _____ DATE: _____

**THEODORE V. BENDEREV, M.D.**
**IPSI – A Medical Corporation**

## FINANCIAL POLICIES

We welcome you to our practice. We are able to concentrate on the practice of medicine and provide quality care by having our financial policies understood by our patients and by avoiding confusion or misunderstandings.

**As a courtesy to our patients, we will bill insurance claims with a maximum of two insurance carriers per patient**. **It is important to emphasize that your insurance is a contract between you and the insurance carrier. Our billing experience has taught us that while filing insurance claims is a courtesy extended to our patients, it is not a guarantee of payment. You will be billed directly for the services rendered if we have not been paid by your insurance carrier within 45 business days. You will then be responsible for the bill.**

Our office staff will bill secondary insurance if the responsible party has given permission to the insurance company to have the payment sent to us. For services not covered by Medicare, a separate arrangement can be made.

Dr. Benderev is not a participating physician with Medi-Cal and therefore, cannot accept Medi-Cal insurance (including retro-active Medi-Cal coverage). For patients without insurance plans or for patients that are unable to provide an insurance card verifying current coverage, we require payment at the time services are rendered. If you do not have insurance or your insurance company does not pay for services rendered it is the patient's responsibility for payment in full. This also applies to patients requesting services who have insurance plans with whom we are not contracted, (e.g., out-of-network coverage). **_____ (patient's initials)**

All monies owed by the patient (e.g. co-payments, deductibles, required "out-of-pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered.

If your account is placed with a collection agency, due to non-payment, you will be responsible for any additional charges this may incur, including collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due.

For patients having surgery, we are happy to provide an estimate of surgical charges. The estimate is based upon present expectations of the tests/procedures and/or services that will be required for your care. Additional services may become necessary and we will attempt to inform the patient as the need for additional services are identified.

Any patient that is seen or treated at IPSI without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively.

Any services rendered by the IPSI that are not a covered benefit of your insurance policy are your responsibility to pay. Our staff will assist you to the best of their knowledge in dealing with your insurance company but it is your responsibility to know and understand your insurance policy.

We accept cash, check, VISA or Master Card. We are willing to work with any patient requesting a financial payment plan. There will be a $45 charge for each check that is returned for insufficient funds.

In accordance with Federal Trade Commission requirements, effective May 1, 2009, we are required to ask our patients to prove their identity by showing a photo ID when visiting our office for the first time AND annually. Please bring your driver's license or other photo ID when you arrive in addition to your current health insurance cards. In order to save you the trouble of showing your ID at every visit, we will make a copy of it when you present it. This way our employees can verify your identity on site. If you don't have a photo ID, please bring a utility bill or other document that shows your correct name and address.

We hope you find this information helpful. Please feel free to ask our office staff if you require any further assistance.

Patient Signature:_____ Date:_____

# PRECAUTIONS FOR SURGERY

All patients anticipating surgical procedures must stop taking aspirin and aspirin products as well as ibuprophen for **10-14 days prior** to procedure. These drugs and other nonsteroidal anti-inflammatory drugs are anticoagulants (blood thinners) which can cause bleeding problems during and following the procedure.

## THE FOLLOWING COMPOUNDS ARE TO BE AVOIDED: FOR 10 TO 14 DAYS PRIOR TO SURGERY.

(Contact your general physician if there is any question whether you need the medicine.)

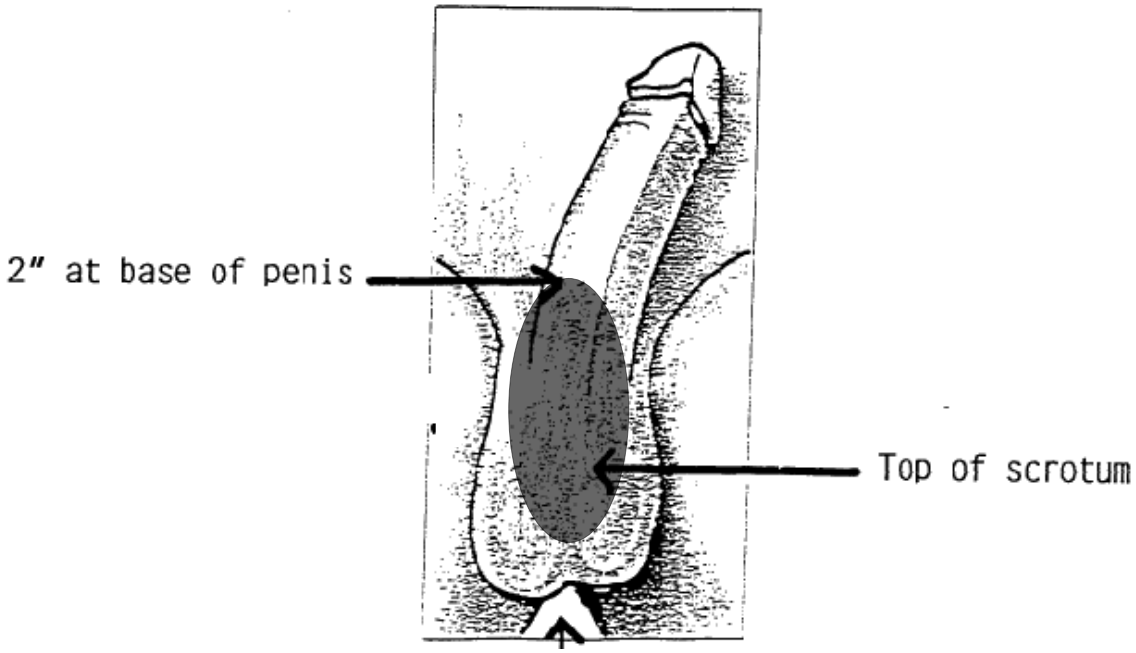
ADVIL
ALKA SELTZER
ALEVE
SELTZER
ANACIN
ANAPROX
ARTHOTEC
ASCRIPITIN
ASPRIN
BAYER
ASPRIN
BEXTRA
BUFFERIN
CAMA
CATAFLAM
CELEBREX
CHERACOL
CLINORIL
CONGESPRIN
COPE
CORICIDIN
DAMASON
DARVON
COMPOUND
DISALCID
DOLOBID
DRISTAN
DURAGESIC
ECOTRIN
EMPIRIN
EQUAGESIC
EXCEDERIN
FELEDENE
FIORINAL
FOUR WAY
COLD
HALFPRIN
HALTRAN
IBUPROPHEN
INDOCIN
LODINE
MEASURIN
MEDIPRIN
MIDOL
MOBIC
MOTRIN
NALFON
NAPROSYN
NAPRELAN
NORGESIC
NUPIN
ORUDIS
ORUVAIL
PAC
PANALGESIC
PERCODIN
PONSTEL
RELAFEN
ROBAXISAL
SALTFLEX
SINE AID
STENDIN
SINE OFF
SUPAC
SYNALGOS
PAC
SYNALGOS DC
TOLECTIN
TORADOL
TRILAMINCAN
TRILISATE
VANQUISH
VIOXX
VOLTAREN

## ALSO AVOID "HERBAL" COMPOUNDS PRIOR TO SURGERY.

A number of herbal remedies have side effects that could complicate surgical procedures by inhibiting blood clotting, affecting blood pressure, or interfering with anesthetics. Ginkgo biloba, feverfew, garlic, ginger, and ginseng have all been shown to interfere with the function of platelets - necessary for clotting. The use of herbal preparations in the United States has risen dramatically over the past decade. Although we do not have the exact rate of complications form herbs, the potential for them to cause a problem is real.

# SHAVING / CLIPPING INSTRUCTIONS
# FOR THE DAY OF VASECTOMY

**On the day of the procedure you should (shave or) preferably clip the hair at the bottom 2 inches of the penis and the top/front of the scrotum.**




**PLEASE CLIP OR SHAVE ON THE <u>DAY OF</u> THE PROCEDURE, <u>NOT THE NIGHT BEFORE.</u>**

**ALSO, PLEASE REMEMBER TO <u>WEAR</u> AN ATHLETIC SUPPORTER OR TIGHT BRIEFS <u>WHEN YOU COME</u> FOR YOUR PROCEDURE.**

**Theodore Val Benderev, M.D.**
**Urology**
IPSI- A Medical Corporation
26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
Phone 949-364-4400

# PATIENT VASECTOMY QUESTIONNAIRE

**Patient Name: _____**

**Date: _____**

**Referred by**: _____

**Describe the health care that you are seeking today:**

**(Chief Complaint)** _____

_____

Your **age**: _____ years old

| **This section for doctor use only** |
|---|
| |
| |
| |

## VASECTOMY HISTORY (Begin Here)

Have you had an infection in the testicle area? Yes No

Have you ever been injured in the scrotal area Yes No

If so, please describe_____
_____

Have you ever had an inguinal hernia repair Yes No

Have you had prostatitis (inflamation of the prostate) before? Yes No

If yes, what medication were you treated with and for how long?
_____
_____

Is there anyone in your family who has had
Prostate cancer? Yes No
If so, which relative was is he? _____

Are you having sexual problems?
Yes No

Have you had any conditions affecting the urine, kidneys, bladder, prostates, testicles or penis?
_____
_____

**Patient Name:**

What main Internet search engine do you use?
_____

Have you had reviewed Vasectomy.com for information on vasectomies?

Yes No

What, if any, additional questions or concerns do you have?
_____
_____
_____

## Your Past Medical & Surgical History:

**Illnesses** – please circle all that apply and list others:

**NONE [ ]**

| | | | |
|---|---|---|---|
| High blood pressure | Diabetes | Bleeding problems | Kidney problems |
| Heart disease | Arthritis | Liver disease/hepatitis | Stomach ulcers/reflux |
| Heart arrhythmia | Osteoporosis | Glaucoma | Thyroid problem |
| Cancer type_____ | Stroke | Heart murmur | Venereal diseases |

Other_____

Hospitalizations (other than surgery): _____

**Operations** – list any operations you have had and the year of each procedure

**NONE [ ]**

_____
_____
_____

**Fractures & Injuries** – list any fractures or serious accidents you have had:

_____

**Medications** – list all prescription and non-prescription medications you use **with the doses**:
(include aspirin, hormones, birth control pills, laxatives, vitamins, calcium and others)

**NONE [ ]**

_____
_____
_____
_____

**ALLERGIES** (include medication, iodine, seafood, latex & others) **REACTION**

**NONE [ ]**

_____ _____
_____ _____
_____ _____
_____ _____

**Your Family's Medical History** – list illnesses of your blood relatives (include heart disease, diabetes, cancer, high blood pressure, kidney disease, gout, osteoporosis, bleeding problems)

| Living relations | Illness | Deceased relations | Illness/Cause of death |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |

**Patient Name:**

**Social History –** please circle or fill in the blank

Tobacco use: Never Presently Past (year quit _____)
Alcohol use: None Occasional Regular _____
Your occupation: _____ Are you retired? Yes No

Marital status: Single Married Divorced Widowed Religious reference (optional)_____
Your partner's name: _____ Partner's occupation_____
How long have you been married to your present wife? ____ years
Is the marriage stable? Y or N

Children by this marriage? _____

| Name | Ages | Sex | Health |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Children from previous marriage: _____ Ages: _____

How many children are living with you: _____

## Complete Review of Systems

Circle any current or recent problems with the following:

| | | |
|---|---|---|
| **CONSTITUTIONAL** | | |
| Any recent weight change | Y | N |
| Fever or chills | Y | N |
| Headache | Y | N |
| **CARDIOVASCULAR** | | |
| Chest pain or angina | Y | N |
| Swelling of legs | Y | N |
| Varicose veins | Y | N |
| **HEMATOLOGIC/LYMPHATIC** | | |
| Easy bruising or bleeding | Y | N |
| Anemia | Y | N |
| Swollen glands | Y | N |
| **MUSCULOSKELETAL** | | |
| Joint pain | Y | N |
| Back pain | Y | N |
| Neck pain | Y | N |
| **NEUROLOGIC** | | |
| Numbness/tingling | Y | N |
| Tremors | Y | N |
| Seizures | Y | N |
| Dizziness | Y | N |

| | | |
|---|---|---|
| **INTEGUMENTARY (SKIN)** | | |
| Skin rash | Y | N |
| Itching | Y | N |
| **RESPIRATORY** | | |
| Cough | Y | N |
| Wheezing | Y | N |
| Shortness of breath | Y | N |
| **GASTROINTESTINAL** | | |
| Abdominal pain | Y | N |
| Nausea or vomiting | Y | N |
| Blood in stool | Y | N |
| Black stool | Y | N |
| Recent change in stool | Y | N |
| Heartburn/indigestion | Y | N |
| Hemorrhoids | Y | N |
| **GENITOURINARY** | | |
| Leaking urine | Y | N |
| Frequent urinary infections | Y | N |
| Urinary retention | Y | N |