

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.

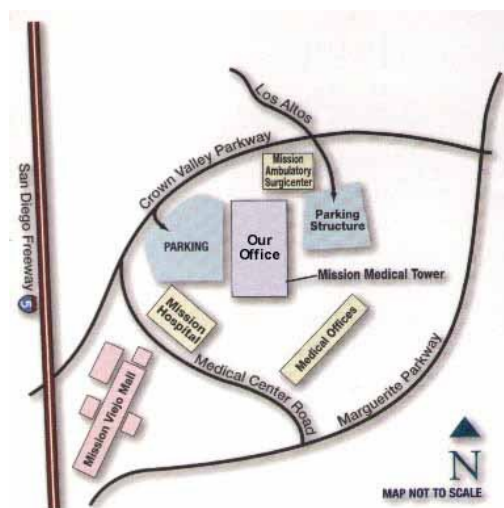
Please remember to wear long pants and wear an athletic supporter (jock strap) or tight briefs when you arrive for your procedure. Make sure that you have a light meal on the morning of the procedure.

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.

PATIENT INFORMATION SHEET - PLEASE COMPLETE IN ITS ENTIRETY

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

DATE: _____

LEGAL NAME - FIRST: _____ LAST: _____ MI _____

STREET: _____ SEX: F M

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: () _____

CELL#: () _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

EMPLOYER: _____ TITLE: _____

EMPLOYER ADDRESS: _____

WORK PHONE #: () _____ MARRIED SINGLE DIVORCED WIDOWED

YOUR PRIMARY CARE PHYSICIAN: _____ PHONE #: () _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

IF REFERRED BY MD, LIST NAME: _____ ADDRESS: _____ PHONE: _____

**PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE TO YOUR APPOINTMENT.
IF YOU DO NOT HAVE PROOF OF INSURANCE - PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED**

MEDICARE # (IF APPLICABLE): _____

PRIMARY INSURANCE ID #: _____ GROUP #: _____ INSURANCE CO: _____

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)

FIRST NAME: _____ LAST: _____ MI: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ EMPLOYER: _____ DRIVERS LICENSE: _____

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. 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, PLUS INTEREST. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME THE SERVICE IS RENDERED IF I DO NOT PRESENT WITH A VALID INSURANCE CARD & DRIVER'S LICENSE. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: _____ DATE: _____

THEODORE V. BENDEREV, M.D.

FINANCIAL POLICIES

We welcome you to our office. 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.

Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. 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. Insurance plans and contracts change constantly. It is your responsibility to contact your insurance company and verify your benefits and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we have not been paid by your insurance carrier within 45 business days.

_____ (patient's initials)

Drs. Benderev is a participating physician with Medicare and accepts assignment for all covered Medicare services. Medicare pays 80% of approved charges and the patient is responsible for the other 20%, after the annual deductible is met. 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.

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 that have insurance plans with which we are not contracted, (e.g., out-of-network coverage). _____ (patient's initials)

All services rendered by Dr. Benderev that is not a covered benefit of your insurance policy is your responsibility to pay. Any patient that is seen or treated without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively. 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. _____ (patient's initials)

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 a monthly interest and penalty fee, collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due. _____ (patient's initials)

While we understand there may be times when our patients need to cancel their appointments, we have found it necessary to implement a "Cancellation and No-Show Policy". Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show." A no-show patient scheduled for an office visit may be charged \$40.00. A no-show patient scheduled for a procedure or diagnostic test may be charged \$100.00. No-show charges are not billable to your insurance company and are your responsibility to pay. _____ (patient's initials)

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.

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.)

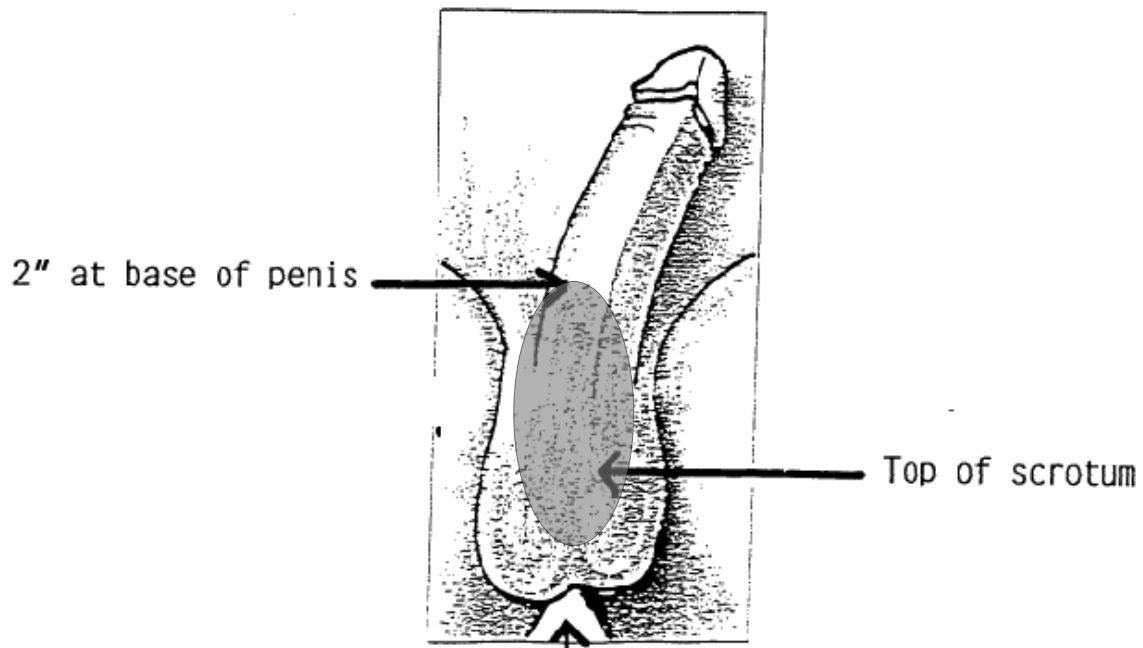
ADVIL	COPE	IBUPROPHEN	RELAFEN
ALKA SELTZER	CORICIDIN	INDOCIN	ROBAXISAL
ALEVE	DAMASON	LODINE	SALTFLEX
SELTZER	DARVON	MEASURIN	SINE AID
ANACIN	COMPOUND	MEDIPRIN	STENDIN
ANAPROX	DISALCID	MIDOL	SINE OFF
ARTHOTEC	DOLOBID	MOBIC	SUPAC
ASCRIPTIN	DRISTAN	MOTRIN	SYNALGOS
ASPRIN	DURAGESIC	NALFON	PAC
BAYER	ECOTRIN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

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 from 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 DAY OF THE PROCEDURE,
NOT THE NIGHT BEFORE.**

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

Theodore Val Benderev, M.D.

Urology

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PATIENT VASECTOMY QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Referred by: _____ **Age:** _____ years old

Describe the health care that you are seeking today:

(Chief Complaint) _____

VASECTOMY HISTORY

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

Have you had prostatitis? Yes No

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

Have you ever been injured in the scrotal area? Yes No

If so, describe _____

Have you ever had an inguinal hernia repair? Yes No

Are you having sexual problems? Yes No

Does your partner wish for you to have a vasectomy? Yes No

Is there anyone in your family who has had prostate cancer?
Yes No

If so, which relative was is he? _____

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

How long ago did you first consider a vasectomy?

___ weeks ago ___ month(s) ago ___ year(s) ago

Please indicate if you have reviewed information on either of these two websites:

[] Vasectomy.MD [] Vasectomy.com

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

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

NONE []

Bleeding Disorder
Diabetes

Heart disease
Hepatitis
Hypertension
Hypothyroidism

Myocardial Infarction (MI)
Cancer, type _____
Renal Stones
Other: _____

Past Surgeries – list any operations you have had and the year of each procedure

NONE []

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

NONE []

Patient Name: _____

Date: _____

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

REACTION

NONE []

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

Living relations	Illness	Deceased relations	Illness/Cause of death
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Social History – please circle or fill in the blank.

Marital status: Single Married Divorced Separated Widowed Remarried

Your occupation: _____ Are you retired? Yes No

How long have you been in your current relationship? ____ months / years

Is your relationship stable? Yes No

How many children do you have? _____ Age Range _____

Are they generally healthy? Yes No

Tobacco use: Never Past: less than 5 years ago 5-10 years ago

 Presently more than 10 years ago

Alcohol use: ____ drinks per week rarely never drink

Review of Systems

Please **circle** all symptoms that you currently have:

Constitutional

Chills
Fever
Weight Gain

Eyes

Blurred Vision
Double Vision

Ears/Nose/Throat/Neck

Dry Mouth
Hearing Loss
Sore Throat

Cardiovascular

Chest Pain
Palpitations
Edema (swelling), location:

Respiratory

Cough
Dyspnea
Dry Cough
Productive Cough

Gastrointestinal

Anorexia
Heartburn
Abdominal Pain

Nausea

Vomiting
Constipation
Diarrhea
Fecal Urgency
Incontinence of Stool
Rectal Bleeding
Black Stool

Genitourinary / Nephrology

Dysuria (burning with urination)
Hematuria (blood in urine)
Urinary Incontinence
Prostatitis

Musculoskeletal

Joint aches (arthralgias)
Back Pain
Gait abnormality (difficulty walking)
Hip Pain
Myalgias (muscle ache)
Neck Pain

Dermatologic

Rash, location:

Neurologic

Confusion

Dizziness

Headaches
Impaired Balance
Memory Loss
Numbness, location:

Parasthesias (funny feeling on your skin) location: _____

Psychiatric

Anxiety
Depression
Easily Distractible
Inability to Concentrate

Endocrine

Alopecia (loss of hair), location:

Change in sex drive (libido)
Drinking large amounts of fluids
(polydipsia)

Hematologic

Easy Bleeding
Easy Bruising

Allergy / Immunology

Nasal Drainage