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
15775 Laguna Canyon Road, Suite 200
Irvine, CA 92618
Phone 949-364-4400

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), Suite #327, Mission Viejo (Our office can be reached by turning at Los Altos off of Crown Valley Parkway) and at 15775 Laguna Canyon Road, Suite 200, Irvine, CA 92618. We do not validate paid 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.

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

THEODORE V. BENDEREV, M.D.

PATIENT INFORMATION SHEET - PLEASE COMPLETE IN ITS ENTIRETY

LEGAL NAME - FIRST:_____ **LAST:**_____ **MI**_____

STREET:_____ **SEX: F M**

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

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

PREFERRED LANGUAGE: _____ **RACE:**_____ **ETHNICITY:**_____

EMPLOYER: _____ **JOB TITLE:** _____

EMPLOYER ADDRESS: _____

WORK PHONE : ( ) _____ ☐**MARRIED** ☐**SINGLE** ☐**DIVORCED** ☐**WIDOWED**

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

REFERRED BY (CHECK ONE): NEWSPAPER ____ **WEBSITE** _____ **DOCTOR** ____ **OTHER** _____

REFERRING PHYSICIAN NAME: _____ **PHONE: ( )**_____

ADDRESS, CITY, STATE, ZIP: _____

REQUIRED TO FILL PRESCRIPTIONS

PHARMACY NAME: _____ **PHONE: ( )**_____

ADDRESS, CITY:_____ **FAX: ( )** _____

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. WE CAN MAKE NO EXCEPTIONS.

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)

FIRST NAME: _____ **LAST:**_____ **MI:**_____

RELATIONSHIP TO PATIENT: _____ **DRIVERS LICENSE #:** _____

DATE OF BIRTH: _____ **EMPLOYER:** _____

EMERGENCY CONTACT

NAME: _____ **PHONE : ( )**_____

RELATIONSHIP TO PATIENT:_____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE INCONTINENCE & PELVIC SUPPORT INSTITUTE (IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH HIPAA REGULATIONS.

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. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: _____ **DATE:** _____

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

You will be asked to sign an arbitration agreement when you come to our office. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by California courts.

By signing this agreement you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time it takes to conduct an arbitration hearing is far less than a jury trial. Further, both parties are spared some of the rigors of trial and the publicity, which may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask.

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.)

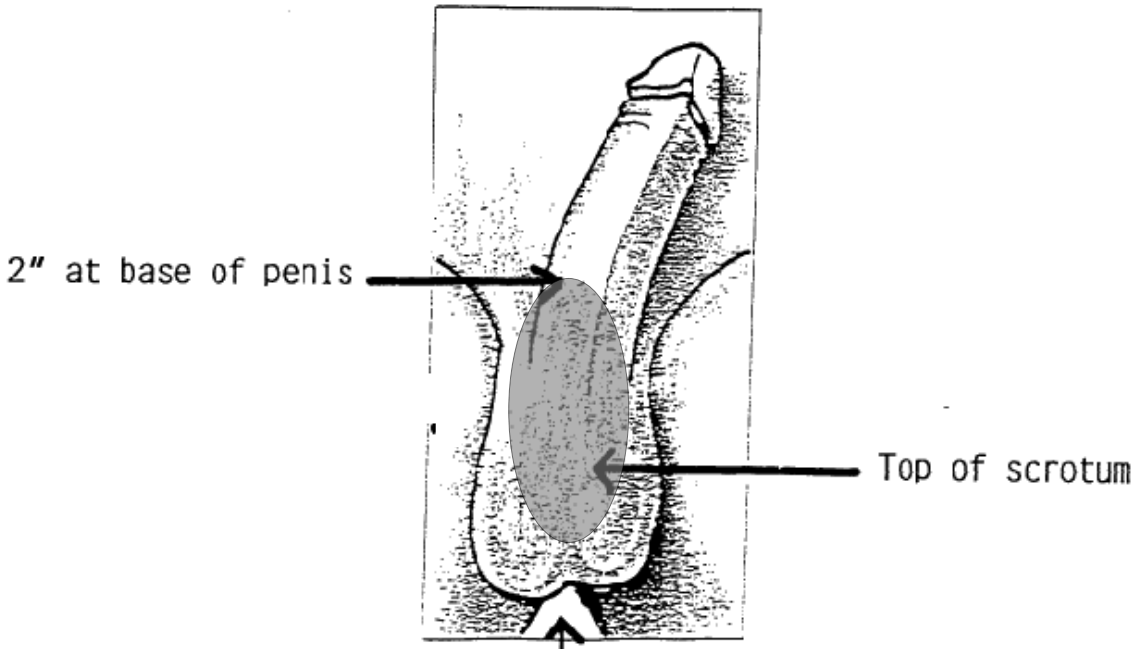
ADVIL
ALKA SELTZER
ALEVE
SELTZER
ANACIN
ANAPROX
ARTHOTEC
ASCRIPITIN
ASPRIN
BAYER
ASPRIN
BEXTRA
BUFFERIN
CAMA
CATAFLAM
CELEBREX
CHERACOL
CLINORIL
CONGESPRIN
COPE
CORICIDIN
DAMASON
DARVON
COMPOUND
DISALCID
DOLOBID
DRISTAN
DURAGESIC
ECOTRIN
EMPIRIN
EQUAGESIC
EXCEDERIN
FELEDENE
FIORINAL
FOUR WAY
COLD
HALFPRIN
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
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Phone 949-364-4400

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 wife / 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 [ ]	Heart disease	Myocardial Infarction (MI)
	Hepatitis	Cancer, type_____
Bleeding Disorder	Hypertension	Renal Stones
Diabetes	Hypothyroidism	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**
_____		_____	
_____		_____	

Social History – please circle or fill in the blank.

Marital status: Single Married Happily Married Unhappily Separated Divorced Remarried Widowed

How many children do you have? From this marriage _____ From Prior Marriage: _____ Age Range _____

Your occupation: _____ Are you retired? Yes No

Tobacco use: Never Smoker Former Smoker Current some day smoker Current Every Day Smoker

Alcohol use: Never drinks Drinks rarely ___ drinks per week

Review of Systems

Please <u>circle</u> all symptoms that you currently have:

NONE [ ]

<u>Constitutional</u>
Chills
Fever
Weight Gain

<u>Eyes</u>
Blurred Vision
Double Vision

<u>Ears/Nose/Throat/Neck</u>
Dry Mouth
Hearing Loss
Sore Throat

<u>Cardiovascular</u>
Chest Pain
Palpitations
Edema (swelling), location:
_____

<u>Respiratory</u>
Cough
Dyspnea
Dry Cough
Productive Cough

<u>Gastrointestinal</u>
Anorexia
Heartburn
Abdominal Pain
Nausea
Vomiting
Constipation
Diarrhea
Fecal Urgency
Incontinence of Stool
Rectal Bleeding
Black Stool

<u>Genitourinary / Nephrology</u>
Dysuria (burning with urination)
Hematuria (blood in urine)
Urinary Incontinence
Prostatitis

<u>Musculoskeletal</u>
Joint aches (arthralgias)
Back Pain
Gait abnormality (difficulty walking)
Hip Pain
Myalgias (muscle ache)
Neck Pain

<u>Dermatologic</u>
Rash, location:
_____

<u>Neurologic</u>
Confusion
Dizziness
Headaches
Impaired Balance
Memory Loss
Numbness, location:
_____
Parasthesias (funny feeling on your skin) location: _____

<u>Psychiatric</u>
Anxiety
Depression
Easily Distractable
Inability to Concentrate

<u>Endocrine</u>
Alopecia (loss of hair), location:
_____
Change in sex drive (libido)
Drinking large amounts of fluids (polydipsia)

<u>Hematologic</u>
Easy Bleeding
Easy Bruising

<u>Allergy / Immunology</u>
Nasal Drainage

Theodore V. Benderev, M.D.

CONFIDENTIAL COMMUNICATION REQUEST

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request I may have made for confidential channel communications.**

Please answer the following two questions by selecting **YES** or **NO**. If you choose to have us leave messages for you, please note those numbers below.

PHONE MESSAGES AND DETAILED INFORMATION

I authorize Drs. Benderev and his agents to leave a voice message regarding non-clinical and clinical information at this number:

__**YES or** __**NO** Phone #: _____.

An example of clinical information would be lab or x-ray results, etc. An example of non-clinical information would be appointment reminders.

I authorize Drs. Benderev and his agents to leave a non-clinical message only at this number:

__**YES or** __**NO** Phone #: _____.

Signed: _____ Date: _____

INCONTINENCE & PELVIC SUPPORT INSTITUTE

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of the Incontinence & Pelvic Support Institute.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 949/364-4400.

I acknowledge receipt of the ***Notice of Privacy Practices*** of the Incontinence & Pelvic Support Institute.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

____ Individual refused to sign notice

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify): _____

_____

_____