International Urogynecology Associates

Dear Patient,

This packet contains information regarding both you and your visit. It is divided into 3 sections.

***Section I** is your **Patient Registration Information**. It is very important that you complete this section and **return it to our office ASAP**. Since it is very important that we receive this information back **prior** to your appointment, we have provided you with 3 ways for you to complete this information and return it to us.*

1. *If we have mailed this packet to you or if you are able to print this out at home, please fax or mail the requested documentation to the address / fax number listed below. Please complete and return to our office no later than 48hrs prior to your appointment. It's important to our physicians and nursing staff that we have your medical history and any other essential information in your chart prior to your appointment.*

2. *If you are completing this patient packet online, please make sure you hit **send** after completing ALL sections. It is also suggested that you print out a copy for your records and bring to your appointment.*

***Section II** is a Bladder Diary. This, too, is very important for Dr. Miklos and Dr. Moore to make a complete diagnosis. We ask that you complete this and bring it with you to your appointment. The frequency volume chart should be for at least a **72-hour period**, prior to your first appointment with the doctor. This is best done over the weekend when you do not have to have the everyday stresses' of work and/or activities. The amount of intake and amount voided do not have to be exact measurements and they can be listed either in cc's or ounces, using any type of measuring container. This information is very helpful to us regarding the management of your condition. We hope you will make every effort to complete this chart.*

***Section III** is important for you to keep for your reference. It contains information regarding women's health and our doctors, both Dr. John R. Miklos and Dr. Robert D. Moore. Driving directions to our office is also included.*

We are looking forward to meeting you!!!!!!

Sincerely,

John R. Miklos, MD
Robert D. Moore, DO

Atlanta Office ~ 3400 Old Milton Parkway Bldg. C ~ Suite 330 ~ Alpharetta, GA 30005
Beverly Hills Office ~ 9201 West Sunset Boulevard ~ Suite 406 ~ Los Angeles, CA 90069
Phone (both locations): 770-475-4499 Fax (both locations): 678-262-3671
www.miklosandmoore.com www.lvratlanta.com

International Urogynecology Associates

Patient Registration Information

Patient Personal Information

Name: (Last, First, Middle Initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Social Security # _____

DOB: _____ Age: _____ Marital Status: Single Married Divorced Widowed

Spouses Name: _____ Spouse Social Security # _____

Emergency Contact _____ ***Phone*** _____

Patient Responsible Party Information

Responsible Party: _____ DOB: _____

Relationship to Patient: SELF SPOUSE OTHER _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Employer: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient Insurance Information

Name of Insured: _____ Relationship to Insured: _____

DOB: _____ Insurance Company: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____ City: _____

State: _____ Zip: _____

Secondary Insurance Company: _____ Relationship to Insured: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____ City: _____

State: _____ Zip: _____

Medical History

Please complete the following information before your first visit

Date of Visit: _____/_____/_____

Name: _____, _____ _____ **Date of Birth:** _____/_____/_____
(Last) (First) (MI)

Chief Complaint (What problem(s) brings you to our office?)

_____

_____

_____

_____

Past Medical History: Please circle Y or N

Y / N Asthma	**Y / N Pneumonia**	**Y / N Ulcers**	**Y / N Tuberculosis**
Y / N Lung Disease	**Y / N Depression/Anxiety**	**Y / N Kidney Infection**	**Y / N Lupus**
Y / N Seizures / Convulsion	**Y / N Venereal Disease**	**Y / N Kidney Stones**	**Y / N Arthritis**
Y / N Heart Disease	**Y / N High Blood Pressure**	**Y / N Arrhythmia**	**Y / N Migraines**
Y / N Stroke	**Y / N Fibromyalgia**		

Y / N Cancer – If yes, what type? _____

Y / N Stomach Problems – type? _____

Y / N Glaucoma – type? _____

Y / N Thyroid Disease – type? _____

Y / N Diabetes – type? _____

Y / N Hepatitis – type? _____

Past Surgical History (List ALL surgeries with the date, if possible)

Previous incontinence / bladder surgeries: _____ NO _____YES Type: _____

Other surgeries (Include any abdominal or plastic surgery procedures)

Procedure:	Date:	Surgeon:	Surgical Facility:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

International Urogynecology Associates

Medical History – Page 2

Name: _____, _____ _____
(Last) (First) (MI)

Allergies **(Please list any allergies along with the type of reaction you experienced):**

_____

_____

Medications **(Please list all medications you currently take, including dosage and how often you take it. also include over-the-counter medications & herbal supplements):**

_____

_____

_____

_____

Social History

Occupation: _____ Race: _____ Religion: _____

Marital Status: _____ Married _____Single _____Divorced _____Widow _____ Separated

Spouse Name: _____ Spouse Occupation: _____

Regular Exercise: _____ Yes _____ No How Often? _____

Are you sexually active? _____ Yes _____ No How Often? _____
(This will help us choose the types of treatments more suitable for your lifestyle)

Cigarettes: Have you ever smoked Cigarettes? _____ Yes _____ No How many years? _____

Packs per day? _____ Are you currently smoking? _____ Yes _____ No

Caffeine: Coffee – cups per day _____ Caffeinated drinks (tea /soda) – cups per day _____

Alcohol: _____ Yes _____ No How often? _____ What is consumed? _____

Illegal Drugs: _____ Yes _____ No How often? _____ Which Drugs? _____

Family History **(Check any conditions in your family & write in their relationship to you)**

Condition	**Relationship**
_____ Heart Disease	_____
_____ High Blood Pressure	_____
_____ Stroke	_____
_____ Breast Cancer	_____
_____ GYN Cancer (Ovarian)	_____
_____ Colon Cancer	_____

GYN History

Last PAP Smear _____ Normal? _____
Last Mammogram _____ Normal? _____
Last GYN Exam _____/_____/_____
Last Menstrual Period _____/_____/_____
Problems with period? _____
Date of Menopause _____/_____/_____
# of Pregnancies _____ # of Deliveries _____
# of Vaginal Deliveries _____
# of C-Sections _____

International Urogynecology Associates

Name: _____, _____ _____
(Last) (First) (MI)

Review of Symptoms **(Check any conditions present today)**

Constitutional

_____ Fever
_____ Chills
_____ Weight Loss

Gastrointestinal

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Blood in Stool
_____ Difficulty Swallowing

Psychiatric

_____ Depression
_____ Nervousness
_____ Anxiety
_____ Mood Swings

Respiratory

_____ Cough
_____ Shortness of Breath

Neurological

_____ Headache
_____ Blurred Vision
_____ Numbness
_____ Tingling
_____ Dizziness

Endocrine / Metabolic

_____ Hot Flashes
_____ Night Sweats
_____ Excessive Thirst
_____ Excessive Hunger
_____ Excessive Urine Output

Cardiovascular

_____ Heart Fluttering
_____ Chest Pain

Skin

_____ Bruise Easily
_____ Rash
_____ Change in Mole
_____ Non-healing Sore

Blood / Lymph

_____ Swollen Glands
_____ Bleeding Problems

Genital / Urinary

_____ Painful Urination
_____ Blood in Urine

_____ **I have none of these problems today**

Please fax, email or mail a completed copy of this paperwork to our office before your scheduled appointment.

DO NOT MAIL ORIGINALS

Keep the original paperwork and bring it with you to your appointment.

International Urogynecology Associates
Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.
(The last two columns on the right are for your doctor to assess your score. Please do not mark anything in these columns).

Patient's Name_____ Today's date:_____

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2	**a**. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3	Are you currently sexually active? **Yes_____ No_____**							
4	**a**. **IF YOU ARE SEXUALLY ACTIVE,** do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5	Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6	Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	**a.** If you have pain, is it usually…		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8	**a.** If you have urgency, is it usually….		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			

SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) – SUBTOTAL		
BOTHER SCORE (2b, 4b, 7b, 8b) - SUBTOTAL		
TOTAL SCORE (Symptom Score + Bother Score) =		

International Urogynecology Associates

QUALITY OF LIFE QUESTIONNAIRE

Name: _____ **Date of Exam:** _____/_____/_____

Has urine leakage and or prolapse affected your:	None	Slightly	Moderately	Greatly
Ability to do household chores?	_____	_____	_____	_____
Physical recreation such as walking, swimming or exercise?	_____	_____	_____	_____
Entertainment activities (movies, concerts, etc)?	_____	_____	_____	_____
Ability to travel by car or bus more than 30 minutes?	_____	_____	_____	_____
Participate in social activities outside the home?	_____	_____	_____	_____
Emotional health (nervousness, depression, etc)?	_____	_____	_____	_____
Feeling frustrated?	_____	_____	_____	_____

Do you experience, and, if so how much are you bothered by:				
Frequent urination?	_____	_____	_____	_____
Urine leakage related to feeling of urgency?	_____	_____	_____	_____
Urine leakage related to physical activity, coughing, or sneezing?	_____	_____	_____	_____
Small amounts of urine leakage (drops)?	_____	_____	_____	_____
Difficulty in emptying your bladder?	_____	_____	_____	_____
Pain or discomfort in the lower abdomen or Genital area?	_____	_____	_____	_____

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International Urogynecology Associates

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____-_____-_____ Date of Birth: _____

I hereby authorize International Urogynecology Associates of Atlanta and Beverly Hills to release information to any medical facility or physician to which I may be referred by this office.

I authorize International Urogynecology Associates of Atlanta and Beverly Hills to release information to any medical facility or physician to which I may be referred by this office to obtain copies of medical information from any medical facility or physician, which may be related to my care and or treatment.

I also authorize International Urogynecology Associates of Atlanta and Beverly Hills to release information to any medical facility or physician to which I may be referred by this office to release medical records from this office, related to my medical history, physical examination, or surgery to other physicians who care for me to provide continuity of care and communication between my physicians on my behalf.

I hereby release this office and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may arise as a result of the release of information authorized by this Consent Form.

I have read and understand this Consent for Release of Medical information and have voluntarily and knowingly signed such consent.

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature

LIST OF PHYSICIANS WHO CARE FOR YOU:

Name	Specialty	Address & Phone Number
Name	Specialty	Address & Phone Number
Name	Specialty	Address & Phone Number
Name	Specialty	Address & Phone Number

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International Urogynecology Associates

AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____-_____-_____ Date of Birth: _____

Name & Address of Physician Sending Records:

_____

_____

_____

_____

The above named physician(s) are hereby authorized to release to:

John R. Miklos, MD ***Robert D. Moore, DO*** ***Gretchen K. Mitchell, MD***

I, _____, *hereby authorize the above named facility/physician to release my medical records, including any psychiatric, alcohol or drug abuse information. Specifically, the following:*

___ Laboratory Reports
___ Progress Reports
___ History / Physical
___ Radiology Reports
___ Discharge Summary
___ Pathology Reports
___ Psychiatric Notes
___ Operative Reports
___ Special Diagnostic Reports (EKG, EEG, etc)
___ Other: _____

The information is needed for the following purpose (check all that apply):

___ Continued care by the receiving facility/physician
___ Claims settlement with insurance company
___ Needed to receive aid by the above named agency
___ Legal proceedings or advise
___ Personal Use
___ Other: _____

SIGNATURE: ***(This authorization is valid for a period of 90 days from the date signed)***
I have read and understand this Consent for Release of Medical Information, and have voluntarily and knowingly signed such consent.

_____ _____
Signature Date

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International Urogynecology Associates

PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

I have been made aware that International Urogynecology Associates of Atlanta and Beverly Hills (also known as Urogynecology, PC) has a Privacy Policy in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of International Urogynecology Associates, I understand and acknowledge the following:

1. *International Urogynecology has a privacy policy in effect in their offices.*

2. *International Urogynecology has made this policy available to me for review, if requested.*

3. *International Urogynecology has made me aware that I am entitled to a copy of this Privacy Policy.*

This practice participates in research studies. Your chart may be reviewed by the staff at International Urogynecology Associates of Atlanta and Beverly Hills to gather data so that we can continue to provide our excellent quality of care. You will not ***be*** *identified. International Urogynecology Associates (Urogynecology, PC) follows all HIPAA regulations.*

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by International Urogynecology and have read and understand this acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ *NO, I do not want a copy, but acknowledge that the Privacy Policy exists.*

_____ *YES, I do want a copy of the Privacy Policy.*

_____	_____	_____
Patient Name	*Patient Signature*	*Date*

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International Urogynecology Associates

Office Policies and Financial Payment Agreement

International Urogynecology Associates of Atlanta and Beverly Hills (also known as Urogynecology, PC) welcomes you. We thank you for selecting us for your healthcare needs. Drs. Miklos and Moore are leading surgeons in the field of urogynecology and all of our physicians take great pride in providing you with the highest quality of care. In order to provide you with the best service, we have the following Office Policies:

ARRIVAL TIME: Please arrive 30-45 minutes before your scheduled appointment time in order to complete the paperwork necessary for your visit. This will help us to keep to the scheduled appointment times. Updating paperwork is required for every visit to the office.

MISSED APPOINTMENTS: Missed office appointments are appointments cancelled or rescheduled with less than 48 hours notice. There is a charge of $250 for missed appointments if you are a new patient and $150 if you are a recurring patient. International Urogynecology Associates of Atlanta and Beverly Hills reserves the right to reschedule patients that arrive more than 15 minutes late for their scheduled appointments. Repeated missed or cancelled appointments may result in termination of services.

RESCHEDULING: Because we are a surgical practice, emergency situations may arise that result in the physician being called away. As a result, your appointment may need to be rescheduled or the physician may run late. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign an Authorization to Release Medical Records form. There is a $45 processing fee that will need to be paid in full before your request can be processed. Please allow two weeks for processing.

PATIENT FORMS: A critical component in our treatment plan is understanding your medical history and particulars about you and your current condition. Thus, it is necessary that you complete the Patient Medical History Questionnaire and other Questionnaires provided prior to your office visit. Failure to provide this information in advance may result in a Missed Appointment. If you need assistance completing the forms, you may choose to arrive 45 minutes before your scheduled appointment and someone will assist you.

FINANCIAL RESPONSIBILTY: International Urogynecology Associates of Atlanta and Beverly Hills (Urogynecology, PC) does not contract with insurance companies, therefore is typically considered an out of network provider and services are often reimbursed at a rate the insurer deems to be "reasonable and customary". Our relationship is with you. As a courtesy to you, we will attempt to obtain a pre-certification and file insurance claims for medically necessary procedures, but all charges (including consultation fees, deductibles, co-insurance, amounts charged in excess of reasonable and customary) are your responsibility. It is important that you read and understand YOUR insurance coverage and benefits and the requirements of your insurer. We expect patients or their guardian to be fully responsible for all charges regardless of insurance coverage. It is your responsibility to follow up with your insurer regarding the payment of your claim.
Please be advised we will not become involved in disputes between you and your insurance company, however, we will provide you with necessary, factual information regarding the services rendered, as necessary to assist you with your claim for benefits.

In the event the insurance company sends the reimbursement check directly to you, it is your responsibility (since we have not asked for payment in full) to send us the check (endorsed over to Urogynecology, PC), along with the Explanation of Benefits to our office.

International Urogynecology Associates

FINANCIAL ESTIMATES: An estimate of proposed surgical procedures and corresponding fees will be provided to you in advance of scheduling your surgery. While every attempt is made to provide you with an accurate estimate, it is possible that additional and/or different procedures may be necessary. We also attempt to provide you with information about what the insurance company has indicated they will reimburse you for any medically necessary procedures, but what they actually pay is out of our control.

FINANCIAL PAYMENT: A **Surgical Deposit** of $1,000 (Georgia patients) or $1,500 (all other patients U.S. and International) is collected at the time surgery is scheduled. This is a *non-refundable* deposit, should you choose to cancel your surgery. Deductibles and estimated co-insurance amounts are collected at the time of the pre-operative office visit. The remainder of your bill is **due and payable within 60 days** (even if your insurance company has not paid their portion of your bill).

Deductibles and Co-Insurance (estimated) are due at the time services are rendered.

Patients without medical insurance will need to pay for services in full, at the time of service. (Payment methods accepted: Cash, Money Orders, Cashiers Checks, Visa, MasterCard, Amex, Discover) Please note: No personal checks over $3500.

COLLECTIONS: I understand that in the event my account becomes past due (over 30 days) and all attempts to arrange payment have failed, my account may be placed for collection. I also understand that I will be responsible for all costs of collection including agency fees, court cost and/or attorney fees.

OUTSTANDING BILLS: There will be a 5% late fee for balances not paid when due unless other arrangements have been made.

RETURNED CHECK or CREDIT CARD CHARGE BACK FEE: $35.00 for each check returned for insufficient funds or credit card charge back.

Should you have any questions regarding this form, please see a member of our front office staff for clarification prior to signing.

Signature of patient or guardian _____

Date:_____

International Urogynecology Associates

COMMON HEALTH INSURANCE COVERAGE TERMS

DEDUCTIBLE: *The deductible refers to the amount* of *money that the patient will need to pay before any payments are made from the insurance company. This is usually* a *yearly amount and will start over, the following year. Some office visit services may be available without meeting the deductible first. This is determined by your insurance company.*

CO-INSURANCE: *This is the amount that would be paid by the patient before the insurance pays. This is in addition to the deductible. Some insurance plans will allow the patient use some services with just the co-insurance payment. Like visiting the doctor, even before the deductible is met. This is determined by your insurance company.*

CO-PAYS: *This is another term used for, or in place* of *"co-insurance". Co-Pays are generally collected for office visit services as* a *flat dollar amount. Coinsurances are generally* a *percentage* of *the total amount due for services.*

LIFETIME MAXIMUM: *This is the maximum amount* of *money the health insurance policy will pay for the entire life. Pay attention to individual lifetime maximums and family lifetime maximums, as they can be different.*

EXCLUSIONS: *The exclusions (non-covered services} are the procedures and examinations that your policy does NOT cover. You will be responsible for these charges.*

PRE-EXISTING CONDITIONS: *This could be* a *disease or illness that the patient had prior to obtaining the insurance policy. Depending on your plan, preexisting conditions may not be covered at all, after* a *certain time frame, or will be covered. This is determined by your insurance company.*

WAITING PERIOD: *This is the time that the patient will have to wait until certain health services are payable by the insurance company. This time frame is determined by your insurance company.*

COORDINATION OF BENEFITS: *If the patient has two* or *more insurance carriers that will cover services, the insurance companies will NOT pay double benefits. In this case, the insurance companies will coordinate benefits to make sure each pays* a *portion* of *the service fees. This is determined by the insurance companies involved.*

GRACE PERIOD: *This is the amount* of *time one ha$ to pay their health insurance premium after the original due date & before coverage is cancelled:*

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International Urogynecology Associates

Insurance Policy

Fees for surgery are not finalized until the surgical procedure has been completed. While we plan certain procedures prior to surgery, one or more may or may not be necessary. Your pre-operative surgical deposit will be applied against the final total surgical fee.

After your surgery, a complete listing of procedures and charges will be submitted directly to your insurance company by this office, on your behalf. In the event that the insurance company reimbursement plus your pre-operative deposit is in excess of the total charges, the difference will be reimbursed directly to you.

Your post-operative visits will be billed directly to your insurance company. Excluding your annual deductible, we agree to accept a reasonable reimbursement in full for your post-operative care.

In the event that the insurance reimbursement is not received within 180 days of submission, you will receive a statement. A payment plan for the balance can be arranged, if needed. **Payment in full is the responsibility of the patient, regardless of the amount of insurance reimbursement.**

We also will assist our patients in submitting appeals to their insurance carrier for additional payment, if you, the patient feels your insurance carrier should make additional payment for our services. However, during the appeals process, the patient will need to make regular payments to keep your account in "active" status. Should your insurance company make the additional payment, we will process to your account and if a refund is due, we will refund directly to you, the patient.

_____ _____

Patient Signature **Date**

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International Urogynecology Associates

INSURANCE PAYMENT/FORWARD AGREEMENT

(BLUE CROSS/BLUE SHIELD ONLY)

International Urogynecology Associates (Urogynecology, PC) is an Out-of-Network provider with patient's who have Blue Cross Blue Shield as their insurance carrier. Because of this, it is standard protocol for Blue Cross Blue Shield to send payments to the patient, for the services that are rendered by an Out-of-Network provider.

As the patient, and the insured by Blue Cross Blue Shield, it is your responsibility to forward all checks and associated paperwork (known as Explanation of Benefits) to our office. This information must be received in our office within 15 days of your receipt from Blue Cross Blue Shield. Failure to comply will result in our office charging your credit card for full amount of payment received by Blue Cross Blue Shield.

I _____, acknowledge the above statement and do understand that I am responsible for making sure all payments paid to me, for services rendered at International Urogynecology Associates is forwarded to them, upon receipt, or I will be charged in full for such payments, not sent immediately.

_____ _____

Patient Signature Date

Card Type: (Check One) VISA AMEX MASTERCARD

Card Number: _____

Expiration Date: _____

Cardholder Name: _____

Billing Zip Code: _____

Authorizing Signature: _____

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International Urogynecology Associates

Physician Payment Authorization

Patient Name: _____

Primary Insurance Policy Holder: _____

Primary Holder Date of Birth: _____

Insurance ID#: _____ Group #: _____

I hereby authorize my above named insurance provide to mail payment directly to said physician at International Urogynecology Associates (Urogynecology, PC), on my behalf. These payments should be made payable and mailed to:

Urogynecology, PC
3400 Old Milton Parkway
Building C, Suite 330
Alpharetta, GA 30005

Should my insurance company send payment directly to me, the patient, I will endorse and forward all payments to International Urogynecology Associates, for the services rendered. All checks will be forwarded to the address above.

I authorize International Urogynecology Associates (Urogynecology, PC) to release any information pertinent to the resolution of claims and receiving payment to all my insurance carriers or attorney working on my behalf.

A photocopy of this assignment shall be considered as valid and effective as the original.

_____ _____
Signature Date

Should you have <u>ANY</u> questions regarding the content of this form, please see a member of our front office staff for clarification, <u>PRIOR TO SIGNING</u>!!

SPECIAL NOTE:

If you will be menstruating at the time of your visit, this does not affect your exam in any way. However, please remove your tampon prior to your exam.

Thank you

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International Urogynecology Associates

Bladder Diary

Patient Name: _____ **Date:** _____

Keep track of your urine output for 72 hours prior to your appointment.

Please measure the amount in ounces or cc's. These markings can be found on a measuring cup. ***This record is VERY IMPORTANT*** *in deciding the treatment for your bladder problems.*

Special Note

If you wear a pessary, please remove it three (3) days PRIOR to your appointment.

Please feel free to contact our office with any questions.

Thank You

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International Urogynecology Associates

Voiding Diary – Day 1

Patient Name: _____ **Date:** _____

Time of Day	Amount Voided (ounces or cc)	Amount of fluid taken in (drinks) oz or cc	Type of fluid consumed (water, tea, beer, etc)	Urgency or pain before voiding? Yes or No	Leakage of urine any time prior to voiding? Yes or No
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 NOON					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 AM					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					
Total for 24 HRS					

Comments: _____

Atlanta Office ~ 3400 Old Milton Parkway Bldg. C ~ Suite 330 ~ Alpharetta, GA 30005
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Phone (both locations): 770-475-4499 Fax (both locations): 678-262-3671
www.miklosandmoore.com www.lvratlanta.com

Voiding Diary – Day 2

Patient Name: _____ **Date:** _____

Time of Day	Amount Voided (ounces or cc)	Amount of fluid taken in (drinks) oz or cc	Type of fluid consumed (water, tea, beer, etc)	Urgency or pain before voiding? Yes or No	Leakage of urine any time prior to voiding? Yes or No
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 NOON					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 AM					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					
Total for 24 HRS					

Comments: _____

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Voiding Diary – Day 3

Patient Name: _____ **Date:** _____

Time of Day	Amount Voided (ounces or cc)	Amount of fluid taken in (drinks) oz or cc	Type of fluid consumed (water, tea, beer, etc)	Urgency or pain before voiding? Yes or No	Leakage of urine any time prior to voiding? Yes or No
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 NOON					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 AM					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					
Total for 24 HRS					

Comments: _____

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International Urogynecology Associates

Directions

Atlanta (Alpharetta) Office

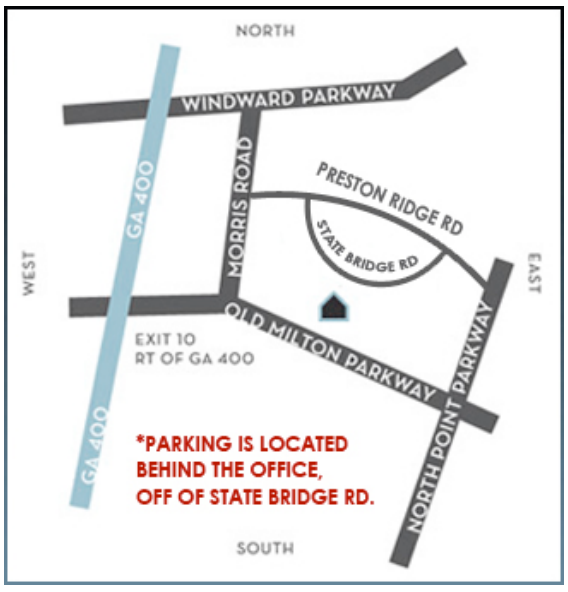
Dr. Miklos and Dr. Moore's practice is located in Alpharetta, about 25 minutes from the Perimeter and 40 minutes from Buckhead.

From the South:
Take 1-85 North, and take the exit for GA. Highway 400. Go through the tollbooth ($.50) and continue on 400 North. Take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the North:
Take Highway 400 South, and take Old Milton Parkway (exit #10). Turn left onto Old Milton Parkway. Turn left at the fourth traffic light onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the East:
Take I-285 West, and take the exit for 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.

From the West:
Take I-285 East, and take the exit for Ga. Hwy. 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the third traffic light- onto Northpoint Parkway. Take the first left into the Northside/Alpharetta Medical Campus. Go up the hill and take a right. The parking structure is straight ahead, and we are in Building C.



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Beverly Hills Office

The Beverly Hills Sunset Surgery Center is located 15 miles from the Los Angeles International Airport (LAX)

Directions from the Valley:
405 South, Exit Sunset Blvd, Left at Exit on Sunset Going East (Approximately 4 Miles)
The Center is on the corner of Doheny and Sunset.

Directions from Los Angeles:
10 West, to the 405 North, Exit Sunset, Go Right (East) on Sunset (Approximately 4 Miles),
The Center is on the Corner of Doheny and Sunset.

Directions from Orange County:
405 North, Exit Sunset and go Right (East) on Sunset (Approximately 4 Miles),
The Center is on the Corner of Doheny and Sunset.

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