WELCOME TO THE UROGYNECOLOGY CENTER!

Your doctor has recommended that you be evaluated by the team at The Urogynecology Center. The Urogynecology Center was established in 1990. Our primary goal is caring for women with problems that include urinary and/or fecal incontinence, pelvic organ prolapse, or chronic pelvic and/or bladder pain. Since the establishment of this center, we have had a very high level of patient satisfaction due to the fact that we are a true subspecialty center devoted specifically to the management of patients with these types of problems. Our philosophy is to help you overcome your problem by performing a comprehensive evaluation beginning with a carefully performed history and physical examination. This is typically followed by some simple office testing utilizing state of the art equipment. The testing, together with the accurate assessment of your history and physical examination, allows us to more accurately diagnose and therefore treat your particular pelvic floor abnormality. After this evaluation, I will review with you the therapeutic options that would appropriately meet your needs. Whenever possible, a nonsurgical or minimally invasive approach will be offered. Your dignity and personal needs are always a major concern to us and will always be considered as we work together to address your specific problems.

The first step in your evaluation requires that you complete new patient paperwork, including a simple questionnaire and bladder diary (a record of how much you drink and how often you urinate). This is done prior to your first visit. I will then carefully review your history and these records so that I can fully understand the nuances of your problems and of your prior history related to your problems. Any and all records from previous care rendered will be reviewed; and therefore, it is always important to bring these records with you to your first visit. A comprehensive physical examination will then be done to determine the extent of any physical concerns, as well as an evaluation of pelvic muscular strength and function.

Your second office visit is designed to do some tests to evaluate your bladder function called **urodynamics** (URO I). These tests involve filling your bladder with water to assess this bladder function and attempting to reproduce your particular symptom (incontinence, bladder pain, urgency, incomplete bladder emptying, etc). We will also want to determine how well you empty your bladder. Therefore, it is very important that when you arrive at the office your bladder is full. **We suggest that you drink 12 oz. of fluid 1½ hours prior to arrival** at the office and attempt to hold your urine until we ask you to void on our special commode. We have found that this is an adequate amount and you do not have to drink more than this. We also need you to be off your anticholinergic medications, such as Detrol, Ditropan, Oxytrol, Sanctura 3 days prior to the test and VESIcare and Enablex for 5 days prior to the test.

The next office visit will be your **cystoscopy** (URO II) will involve a small scope designed for a woman's bladder. The scope will be used to visualize the inside of your bladder and urethra to further evaluate bladder anatomy and function. Therefore, it is very important that when you arrive at the office your bladder is full. We suggest that you drink at least 12 oz. of fluid 1½ hours prior to arrival at the office and attempt to hold your urine until we ask you to void on our special commode. I will then discuss with you (and your family when appropriate) the probable cause of your symptoms, and review with you the management plan that fits your needs.

Please note that you have been scheduled for these outpatient diagnostic testing procedures that are performed in the physician's office. This means that the patient may be responsible for any amount of the deductible that has not been met plus the coinsurance. Due to the expense of these procedures, it is strongly recommended that you review your plan benefits. You may contact your insurance company prior to your visit and find out what your plan benefits are. See page 3 for important patient information and financial policies.

Enclosed you will find paperwork to be filled out and brought with you to your first visit. Please do not mail this paperwork. Also, remember to bring with you (or they can be faxed) any medical records that would assist me in understanding your past history of treatment for your symptoms. Please feel free to call with any questions.

I look forward to meeting you.

Charles (Chip) Butrick, M.D.
Director of The Urogynecology Center

Visit our website at www.urogyncenter.com

Phone number: 913-307-0044
Fax Number: 913-227-0094

The Urogynecology Center LLC
6730 W 121st Street
Overland Park, KS 66209
Phone: (913) 307-0044 Fax: (913) 227-0094

Patient Questionnaire

IMPORTANT: Please complete this questionnaire carefully and bring it to your appointment.

Name: First __________________ M.___Last________________________ Date of Birth: ___/___/___ Date of Visit: ____/____/____

Former Name/Nickname:_________________________ Email: _______________________ Employer: _______________________

Home Address: _______________________________ Apt: ______ City: _______________________ State: _____ Zip: __________

Home Phone Number: ___________________________ Cell: __________________________ Work: ______________________

Marital Status (Please Circle One): Single Married Divorced Separated Widowed SS#: ___________-________-____________

Responsible Party: ____ Phone #: _____________________________________

Please circle or fill in the blank:

EMPLOYMENT: Full-time - Part-time - Retired - Self-Employed - Not Employed

STUDENT: Full-time - Part-time - Not a student

ETHNICITY: Hispanic/ Latino - Not Hispanic/Latino - Prefer not to answer

RACE: Native American - Alaska Native - Asian - Native Hawaiian
Other Pacific Islander - African American - White - Hispanic
Other____________ - Prefer not to answer

PREFERRED LANGUAGE: English - Spanish - Other __________

Pharmacy: Local: ____ Phone Number: ________________________

Mail Order: ____ Phone Number: ________________________

Who referred you to our office and/or how did you hear about us? ____
Would you accept a life saving blood transfusion? Yes / No

Physicians:

Primary Care Physician: ____ Phone Number: ______________________________

OB/GYN: ____ Phone Number: ______________________________

Cardiologist: ____ Phone Number: ______________________________

Other: ____ Phone Number: ______________________________

Insurance: Primary Insurance: ___________________________ Secondary Insurance: _____________________________

Subscriber/DOB: ______________________________ Subscriber/DOB:___________________________________

ID & Group No: _______________________________ ID & Group No: _______________________________

Assignment of Benefits

I hereby authorize The Urogynecology Center, LLC to file my insurance/Medicare/Medigap and assign benefits directly payable to The Urogynecology Center, LLC/Charles Butrick, M. D. I authorize The Urogynecology Center, LLC to release any medical information that may be necessary for my medical care for the processing of financial benefits. I further agree that a photocopy of the agreement shall be as valid as the original.

PATIENT/Guardian **SIGNATURE:** ____ **DATE:** ____________________

THE Urogynecology CENTER

Specializing in Incontinence, Pelvic Pain, and Pelvic Reconstruction

* IMPORTANT PATIENT INFORMATION & FINANCIAL POLICIES *

It is the patient's responsibility to know and understand their insurance. Please contact your insurance company if you are unaware of what your insurance deductible, coinsurance, co-pay, and out of pocket expenses are.

*Surgery and in office procedures including but not limited to urodynamics, cystoscopy, and appell cocktails will be applied to your unmet deductible and coinsurance per your plan. These costs may have a significant impact on your finances. Should your condition require surgery, we require a payment of ½ of your outstanding balance when your surgery is scheduled. We then require your remaining balance to be paid in full before your surgery date. This policy helps protect the patient from the burden of unmanageable medical bills.

Please contact our billing personnel with any questions regarding your out of pocket expenses.

1. **Insurance.** All patients must complete our patient information form. 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 insurance information in a timely manner, you may be responsible for the balance of a claim.
2. **Co-payments and deductibles.** Deductibles and co-payments should be paid at the time of service. Any coinsurance amount due may be billed to you at our discretion after the claim is processed by your insurance company. We accept cash, check, MasterCard, Visa, Discover, and American Express.
3. **Non-covered services**. Please be aware that on rare occasions the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonable or necessary by Medicare or other insurers. We will make every attempt to notify the patient before the procedure if this is the case. You must pay for these services in full at the time of visit.
4. **Nonpayment.** If for some reason your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay on your account. Please be aware that if a balance remains unpaid, we may refer your account to our outside collection agency.
5. **Returned checks.** Please be advised there is a $30 fee for any returned check.
6. **No show/cancellation Policy. If we do not receive 24 hours notice to cancel or reschedule your appointment, we will charge a $125.00 no show/cancellation fee before you can schedule your next visit.**

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

I have read and understand the financial and payment policies and agree to abide by their guidelines.

____

Name: Print (Parent or Legal Guardian if Minor Child) Date

____

Name: Signature (Parent or Legal Guardian if Minor Child)

Patient Name:____ **D.O.B.**____________________

CHIEF COMPLAINT

Please briefly describe the reason(s) that you are being seen in our office: ____
____

For how long have you experienced each problem? ____

PAST MEDICAL HISTORY

Have you ever had any of the following problems? Please circle Yes or No and if yes, please explain:

		EXPLAIN:
Yes / No	Bleeding problems (blood clots, anemia, past transfusions)	____________________
Yes / No	Cancer	____________________
Yes / No	Diabetes	____________________
Yes / No	Eye Disorder (glaucoma, chronic dryness)	____________________
Yes / No	Neurological problems (seizures, migraines, stroke, fibromyalgia)	____________________
Yes / No	Gastrointestinal disorder (ulcers, reflux, IBS)	____________________
Yes / No	Heart problems (irregular heart beat, murmur)	____________________
Yes / No	Hernia	____________________
Yes / No	High Blood Pressure	____________________
Yes / No	Kidney problems (stones, infection, decreased function)	____________________
Yes / No	Liver Problems (hepatitis, gallbladder disease)	____________________
Yes / No	Musculoskeletal problems (osteoarthritis, loose joints, fibromyalgia)	____________________
Yes / No	Psychiatric problems (depression, anxiety, bipolar disorder)	____________________
Yes / No	Respiratory problems (asthma, COPD, emphysema, sleep apnea)	____________________
Yes / No	Skin disorder (herpes, psoriasis)	____________________
Yes / No	Spine injury	____________________
Yes / No	Thyroid disease	____________________
Yes / No	Other:	____________________

SURGICAL HISTORY

☐ **I have never had any type of surgery – skip this section.**

List ALL surgeries with the date, if possible. Include abdominal and plastic surgeries, also include date:

____
____
____
____

ALLERGIES

Allergic To:	Reaction	Allergic To:	Reaction
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

MEDICATIONS

☐ **I do not take any medications – skip this section.**

List all of the medications that you currently take, including over-the-counter medications and herbal supplements. List the dosage and how often you take it.

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Patient Name:____ **D.O.B.** ______________________

OBSTETRICAL HISTORY

☐ I have never been pregnant – skip this section.

Number of pregnancies: _____ **Miscarriages:** _____ **Abortions:** _____ **Living Children:** _____

Date of Childs Birth:	Birth Weight:	Type of Delivery:		
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section
____________________	____________	☐ Vaginal	☐ Forceps / Vacuum	☐ C-section

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Living situation ☐ Alone ☐ Family ☐ Skilled nursing facility/nursing home ☐ Other__________

Sexually Active ☐ Yes ☐ No

Tobacco use: ☐ Yes ☐ No **Daily amount:** ________________ **# of years:** ______________

Alcohol use: ☐ Yes ☐ No **Amount:** ____

Street drug use: ☐ Yes ☐ No **Type/amount:** ____

Caffeine use: ☐ Yes ☐ No **Type/amount:** ____

Exercise: ☐ Yes ☐ No **Describe:** ____

Sexual Abuse: ☐ Yes ☐ No: **Describe:** ____

FAMILY HISTORY

Please circle Yes or No and complete the relationship portion:

		RELATIONSHIP
YES / NO	Bleeding disorder	______________________________________
YES / NO	Cancer (list type)	______________________________________
YES / NO	Diabetes (Type)	______________________________________
YES / NO	Heart disease	______________________________________
YES / NO	Hernia or vaginal prolapse	______________________________________
YES / NO	Urinary problems	______________________________________
YES / NO	Other	______________________________________

Patient Name: ____ D.O.B: ____________________

Review of Systems

Check any conditions you've had in the past six months:

Constitutional
- ☐ Recent weight change
- ☐ Fever
- ☐ Weakness
- ☐ Other:_______________

HEENT
- ☐ Visual problems
- ☐ Hearing Problems
- ☐ Dry Mouth
- ☐ Other:___________

Cardiovascular
- ☐ Chest Pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High blood pressure

Respiratory
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other:___________

Gastrointestinal
- ☐ Heartburn/Indigestion
- ☐ Nausea/Vomitiing
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Constipation/Diarrhea
- ☐ Fecal Incontinence
- ☐ Other:________________

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Limited mobility
- ☐ Other:____________

Neurological
- ☐ Paralysis
- ☐ Numbness
- ☐ Tingling
- ☐ Dizzy Spells
- ☐ Headaches
- ☐ Insomnia
- ☐ Memory loss

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Persistent itch/hives
- ☐ Other:___________

Endocrine
- ☐ Hot flashes
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Other:____________

Hematological
- ☐ Easy bruising
- ☐ DVT
- ☐ Blood Clotting
- ☐ Other

Immunologic
- ☐ Swollen Lymph nodes
- ☐ Anxiety
- ☐ Other:_____________

Psychiatric
- ☐ Depression
- ☐ Other:___________

Gynecological
- ☐ Abnormal bleeding
- ☐ Painful periods
- ☐ Painful intercourse
- ☐ PMS
- ☐ Infertility
- ☐ Abnormal vaginal discharge
- ☐ Frequent yeast infections

Urinary
- ☐ Recurrent UTI's
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Urinary Incontinence (Leakage)

Breasts
- ☐ Pain in breast
- ☐ Nipple discharge
- ☐ Breast lump(s)

Eyes
- ☐ Blurred vision
- ☐ Glaucoma

☐ YES ☐ NO **Do you feel satisfied with your life?**
Comments: ____

☐ YES ☐ NO **Do you feel severely depressed?**
Comments: ____

☐ YES ☐ NO **Have you considered suicide in the last 12 months?**
Comments: ____

☐ YES ☐ NO **Have you ever had: AIDS, Hepatitis or other viral condition(s)?**
Comments: ____

Patient Name: ____ D.O.B. ___________________________

UROGYNECOLOGIC QUESTIONNAIRE

1. **I urinate every ____________ hours during the day.**
2. **At night, I get up __________ times to urinate**

YES / NO **Do you lose urine with laughing, sneezing or exertion?**

What amount of urine do you lose? Small Large
In what position do you lose urine? Sitting Standing Lying down

YES / NO **Do you lose urine with a strong sense of urgency?**

YES / NO **Does the sound , sight, or feel of running water make you lose urine?**

YES / NO **Do you lose urine without any warning (without activity or urgency)?**

YES / NO **Do you wear a pad? If so, how many pads per 24 hours? _______________**

YES / NO **Is it difficult to get your urine stream started?**

YES / NO **Does your urine stream seem slow or weak**

YES / NO **Do you feel that you empty your bladder completely when you urinate?**

YES / NO **Do you have pain associated with urination?**

YES / NO **Do you have frequent bladder infections?**

YES / NO **Did you have childhood problems with your bladder (bed wetting, etc.)?**

YES / NO **Do you feel as if your pelvic organs are “falling down”?**

YES / NO **Do you feel a bulge at the opening of your vagina?**

BOWEL FUNCTION QUIESTIONNAIRE

I move my bowels ________ times per day or _______ times per week.

YES / NO **Do you have difficulty emptying your rectum?**

What is the consistency of your stool when this happens? Liquid Soft Normal Hard

YES / NO **Does it help to press on the inside or outside of the vagina?**

YES / NO **Do you lose control of stool?**

What is the consistency of your stool when this happens? Liquid Soft Normal Hard

YES / NO **Do you have problems controlling gas?**

YES / NO **Do you have alternating constipation and diarrhea?**

YES / NO **Do you have pain with bowel movements?**

YES / NO **Do you ever see blood in your stools?**

YES / NO **Did you have childhood problems with your bowels?**

Patient Name: ____ **D.O.B:** ____________________

COSMETIC GYNECOLOGY QUESTIONNAIRE

YES / NO I am self-conscious about the appearance of my vulva/vagina.

YES / NO I am unhappy with the way vagina looks (i.e. gaping).

YES / NO I am unhappy with the way my labia look (irregular, dark, long)

YES / NO My labia rubs or pulls on my clothing or during sex.

YES / NO I am unable to wear the type of clothing that I want to.

YES / NO My vagina feels loose during sex.

YES / NO I have decreased sensation during sex.

YES / NO I wish to enhance my pleasure with sex.

YES / NO I want cosmetic vaginal surgery.

SEXUAL FUNCTION QUESTIONNAIRE

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other

YES / NO I have low desire to participate in sexual activity.
YES / NO I am unable to reach an orgasm.
YES / NO I have significant difficulty reaching orgasm.
YES / NO I have a difficult time becoming aroused during sexual activity.
YES / NO I do not become sufficiently lubricated with sexual activity.
YES / NO I experience pain with vaginal penetration
YES / NO Given all the advancements in the treatment of sexual dysfunction, would you be interested in seeing a clinician to help you with your symptoms?

DERMAL AESTHETIC QUESTIONNAIRE

YES / NO Do you have any concerns with the appearance of your skin?

YES / NO Do you have any issues with Spider veins/varicose veins?

YES / NO Do you have any Anti aging skin care concerns?

YES / NO Do you want to learn more about Skin care products?

YES / NO Do you have any issues with wrinkles or fine lines?

YES / NO Do you have any issues with Sun spots/Age spots?

YES / NO Do you have any concerns with Aging/dull looking skin?

YES / NO Do you have any issues with Large pores/Skin texture?

YES / NO Do you have any concern with Flushing of the skin/Redness?

YES / NO Do you have any interest in Laser Hair Removal?

If yes, what areas: ____

Additional Comments/Notes: ____

____

____

____

____

FIGURE 3

PELVIC PAIN AND URGENCY/FREQUENCY (PUF) PATIENT SYMPTOM SCALE

Patient's Name:______________________ Today's date: ______________

Please circle the answer that best describes how you feel for each question.

		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 bothers	Occasionally	Usually	Always			
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 activity?	Never	Occasionally	Usually	Always			
	b. If you have pain, does it make you avoid sexual activity?	Never	Occasionally	Usually	Always			
5	Do you have pain associated with your bladder or in your pelvis (vagina, labia, lower abdomen, urethra, perineum, penis, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6	a. If you have pain, is it usually		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
7	Do you still have urgency after you go to the bathroom?	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, 6a, 7, 8a)							
	BOTHER SCORE (2b, 4b, 6b, 8b)							
	TOTAL SCORE (Symptom Score + Bother Score) =							

Total score ranges are from 1 to 35.
A total score of 10-14 = 74% likelihood of positive PST; 15-19 = 76%; 20+ = 91% Potassium Positive

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PLEASE COMPLETE THIS DIARY AND HAVE READY FOR YOUR FIRST APPOINTMENT.

Bladder Diary

To help us evaluate your problem and bladder function we ask that you complete this diary. We may also have you complete a diary to evaluate your response to therapy. We need you to keep track of the amount of liquids you drink and the amount you void in *ONE DAY*- any day prior to first appointment. Please complete this form even if you do not feel that your appointment is for a bladder problem. **Many times other conditions can be identified with the bladder diary.**

It is **very important that you complete** the diary **before** your first appointment. If you have any questions please call the office and speak with one of the nurses. **913-307-0044 ext 2**.

INSTRUCTIONS:

1) Fill out one sheet for each day. Please record for a full 24 hour period.
2) Record the time you drink and the amount and the type of fluid. Please use ounces or cc's (ml is same as cc) measurements,
3) Record the time and amount of urine voided, catheterized, or accidents. If accidents, please estimate amount by small, moderate, or large amount of loss.
   (We do not need the urine specimen, just the amounts you measure.)
4) A 24 hour diary is all that is needed unless you have been instructed to do one for a longer period of time.

You can pick up a measuring "hat" to place in the toilet for catching the urine to measure free of charge from our office, or you can get a similar device from most pharmacies for approximately $2.00. A measuring cup works just as well as the measuring "hat" if you are not able to get one from the pharmacy or are unable to make it by our office before you first appointment. You can also use any type of cup or bowl that you have at home to catch the urine to measure.

5) Below is an example of a diary. A blank diary is provided for you to use. If you need additional spaces, please make a copy.

Time	Amount of Fluid Intake & Type	Volume of Urine Voided	Symptoms or reason for accident(e.g. pain, urge too strong, cough, exercise)	Small Accident	Moderate Accident	Large Accident
7:10 am		8 oz	Urge too strong			
7:30 am	12 oz of coffee					
7:49 am		12 oz	No accident			
8:30 am	8 oz of coffee					
8:42 am		3 oz	Did have burning after urinating.			
10:30 am		8 oz	Cough			
10:35 am	10 oz Tea					
11:30 am	12 oz Diet Coke					

BLADDER DIARY

NAME: ____ DATE: _______________________

TIME	AMOUNT OF FLUID INTAKE AND TYPE	VOLUME OF URINE VOIDED	SYMPTOMS OR REASON FOR ACCIDENT (e.g. PAIN, URGE TOO STRONG, COUGH)	SMALL ACCIDENT	MODERATE ACCIDENT	LARGE ACCIDENT

The Urogynecology Center, LLC
AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION

Charles W. Butrick, MD
Margaret R. Sanford, APRN, WHNP
Nancy J. Mason, APRN, WHNP

6730 W. 121st Street
Overland Park, KS 66209-2002

Phone: (913) 307-0044
Fax: (913) 227-0094

I hereby authorize:____

(Person or facility)

To disclose my health information to:____

(Person or facility)

Information to be disclosed including dates: ____

Information listed below will NOT be routinely disclosed unless initialed for authorization:

__________ Alcohol/Drug Abuse Treatment records
__________ Abortion information
__________ AIDS
__________ Mental Health
__________ STD's
__________ HIV

(If ALL information were to be disclosed, if could include the following: Notes by physician, physical therapy, dietary, etc,; phone messages, test and imaging results: medical history; referrals, correspondence and copies of complete health forms.)

I understand that once the uses/disclosures have been made as permitted by this form, the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by delivering in writing a revocation to The Urogynecology Center, but if I do, it will not have any effect on actions The Urogynecology Center took in reliance on this authorization prior to receiving the revocation. I authorize the use/disclosure of the records/information described above.

____ ________________

Name: Print (Parent or Legal Guardian if Minor Child) D.O.B. Date

____

Name: Signature (Parent or Legal Guardian if Minor Child)

Expires (not to exceed 1 yr): ________________

******** PREPAYMENT OF CHARGES FOR DUPLICATION OF RECORDS IS REQUIRED ********

Please allow 10-15 days processing.

No charges if records are sent to a healthcare provider.

Charges $________________________ **Date released** ______/______/______ **Reviewed by:** ___________________________

1. When we contact you may we leave a message:

- on your home phone ___ Yes ___ No
- on your cell phone ___ Yes ___ No

2. Emergency contact:____

3. I give permission to discuss my medical information, including billing information with the following persons:

Name:____

Relationship:____

Phone number:____

4. A copy of the HIPAA policy is available upon request at the front desk.

______________________________ ______________________________
Patient Signature Date

Charles W. Butrick, MD., Director
6730 W 121st Street, Overland Park, KS 66209
Phone: 913-307-0044 Fax: 913-227-0094 www.urogyncenter.com