



GYNECOLOGY



In-Office Surgery Scheduling Request

Patient Name: _____ Date of Birth: _____

Primary Language: English / Spanish / Other: _____

Encompass Payment Discussed: Yes / No (Please Circle)

Patient Cell Number: _____

Home Number: _____

Work Number: _____

Email Address: _____

Physician's Name: _____

Date of Procedure: _____ Time of Procedure: _____

Select Type of Procedure:

- Hysteroscopy
- Hysteroscopy with D&C
- Operative Hysteroscopy (Polypectomy)
- Bartholin Gland Cyst Removal
- Endometrial Ablation - Novasure / Thermachoice / HTA
- Hysteroscopic Tubal Sterilization - Essure / Adiana
- Leep - IV Sedation / Local Block
- Labial Reduction
- Hymenectomy
- Annual Exam with IV Sedation
- Urodynamic Testing
- Other: _____

Insurance Provider: _____ Self Pay? _____

Type of Policy: PPO HMO POS EPO

Special Notes: _____

PLEASE FAX AS SOON AS POSSIBLE TO:

866.562.2978

If you have questions, please contact our Corporate Office at: 972-632-1200



Patient Billing Information

Due to the fact that Encompass is an out of network provider, there will be a prompt-pay co-insurance charge as follows:

Endometrial Ablation	\$345.00
Operative/Diagnostic Hyst	\$345.00
Hysteroscopic Polypectomy	\$345.00
Labial Reduction	\$345.00
Hysteroscopic Sterilization	\$345.00
Leeps	\$345.00

This will be the only fee that you pay Encompass. Encompass accepts all major Credit Cards, Money Orders and Cash. No personal checks, please.

*There will be a \$10 convenience fee when paying with credit card.

If you do not have insurance coverage:

Encompass Fee	\$500.00
Anesthesia Fee	\$500.00
Physician Fee	_____

To provide you the best possible care in a safe and secure environment, your Physician will perform your procedure in his office with the assistance of the anesthesiologist and the services of Encompass Office Solutions, Inc. Your Physician, Encompass and the Anesthesiologist will bill your insurance company for services at the time of your procedure. You may be billed a co-insurance fee for the anesthesia services. Please feel free to contact the anesthesiologist billing office for additional detail.

This letter clarifies the financial billing issues relating to this procedure. There will be two or three separate charges submitted to you insurance carrier.

There may be cases where the payment to Encompass Solutions, Inc. from your insurance company will be mailed directly to you. In this case, you are responsible for submitting payment to Encompass. Endorse the back of the check and send it to our office as soon as possible. If your insurance does not participate with Encompass Solutions, Inc., they have agreed not to bill you the balance difference.

Signature of Patient

Date



SURGERY INSTRUCTIONS

**** As an important part of your anesthetic safety during your procedure, we ask that you DO NOT eat or drink anything 8 hours prior to your scheduled procedure start time (this includes no gum, mints, coffee or water, please). ****

Patient Name: _____

Procedure: _____

Date: _____

Time: _____

Arrival Time: _____

- 1. DO NOT eat or drink anything 8 hours prior to your scheduled procedure.**
- 2. Please arrive 1 hour before your scheduled procedure start time. Allow plenty of time for traffic and weather. We want you to be relaxed.**
- 3. You will have 3 separate payments for this procedure. (Physician, Encompass, Anesthesia). Anesthesia will be billed after your procedure.**
- 4. You MUST have a friend or family member drive you home after your procedure.**
- 5. Wear loose fitting, comfortable clothing. Socks are suggested to keep you warm.**
- 6. An Encompass Patient Relations representative will be calling you to review these instructions and to collect Encompass payment.**
- 7. Your physician will request a urine sample upon arrival as a standard of care before surgery**



Informed Surgical Consent

Patient: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I request Dr. _____ as my physician and such associated, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as:

_____.

I (we) understand that the following surgical, medical and /or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

_____.

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their judgment.

I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of this surgical, medical and /or diagnostic procedure(s). There is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:



Conization of cervix: hemorrhage with possible hysterectomy to control, sterility, injury to bladder or rectum, failure of procedure to remove all of cervical abnormality.

OR

Dilation and curettage of uterus: (diagnostic/therapeutic): Hemorrhage with possible hysterectomy, perforation of the uterus, sterility, injury to bowel and/or bladder.

OR

OTHER:

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I(we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me(us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

PATIENT or LEGALLY RESPONSIBLE PERSON SIGNATURE:

DATE: _____ TIME: _____ A.M./P.M.

Witness: _____

Print: _____



PATIENT HEALTH QUESTIONNAIRE

Questions: Please answer	YES	NO	
Are you allergic to anything, including pesticides, eggs, soy or latex?			
If yes, list:			
Have you ever had any operations? If yes, list:			
Have you or anyone related to you ever had a problem with anesthesia?			
Do you smoke? If yes how many packs per day?			
Do you have a cough?			
Have you ever had asthma?			
Have you recently had a cold?			
Have you had any difficulties with breathing?			
Have you ever had any motion sickness?			
Have you ever had an abnormal Chest X-ray?			
Do you have any bleeding tendencies?			
Have you ever been anemic?			
Do you have a heart murmur?			
Have you ever had a heart attack?			
Do you have a pacemaker?			
Have you ever had angina or pain in the chest related to your heart?			
DO you ever awake short of breath at night?			
Do you have diabetes?			
Do you have high blood pressure?			
Have you ever had thyroid problems?			
Have you ever had a stroke?			
Have you ever had epilepsy, seizures, or falling out?			
Do you have frequent headaches?			
Have you ever had an eye problem?			
Do you wear contact lens?			
Have you ever had kidney disease?			
Have you ever been jaundiced?			
Have you ever had hepatitis?			
Do you have an arm or leg that becomes numb or weak frequently?			
Do you have any physical disabilities?			
Do you have chipped or loose teeth, dentures, caps, bridgework, or braces?			
Do you use alcohol? If yes how many drinks per day?			
Have you ever been under the care of a psychiatrist?			
Have you now or have you ever used "street drugs"?			
Is there any possibility you have been exposed to HIV virus?			
Could you be pregnant?			
Are currently taking any Medications: If yes list below:			
1			
2			
3			

Name: _____ Date of Birth: _____

Height: _____ ft. _____ in. Weight: _____ lbs. Physician: _____