Thank you for selecting Dr. Uzoma Nwaubani, MD. FACOG - NUWA WORLD as your Urogynecologist/Pelvic surgeon. We look forward to you joining our family.

In order to insure a full assessment we have to have the COMPLETED New Patient Packet in our office no later than one week before your appointment. In order to obtain necessary information we've asked that you fill out and sign the Authorization for Release of Medical Information. It is very important that you have the paperwork completed entirely. This will ensure that you will have a thorough new patient visit and an accurate diagnosis.

We thank you for your understanding and cooperation.

Please return this packet to our office no later than: _____

Failure to do so WILL result in a rescheduling of your appointment.

**If you would like to be on our cancellation list please return as soon as you can

Thank you for choosing NUWA WORLD.
We appreciate this opportunity to work with you. In an effort to maximize our efficiency during your appointment time, we would appreciate you completing the following intake form Prior to your appointment.

Today's date_____ Primary Care Physician _____

Referred by _____

Name_____ DOB_____ Age _____

Home phone_____ Cell phone_____

Social Security #_____

Adress_____

Email Address_____

Occupation_____ Employer_____

Work phone_____

Emergency contact_____ Relationship_____

Phone_____

Caucasian/African American/Asian/Hispanic/Other

Single/Married/Divorced/ Separated/Widowed

Preferred Local Pharmacy_____

Address and phone number_____

Preferred Mail Order Pharmacy/phone number_____

Prescription Refill Policy

Refills for current medication can be accomplished by:

1. Calling your Pharmacy and they will transmit a request
2. Keeping an up to date list and requesting at the time of your appointment
3. Calling our nurse's line and leaving a message on the voicemail

Please note:

1. Refill requests received from a pharmacy will be accomplished within 48 business hours
2. Drop-in and call-in requests for prescription refills will be addressed at the end of the business day and subject to a 72 business hour wait period from that time.
3. Please do not leave multiple requests for the same medication.
4. If you are completely out of a medication you can contact your pharmacy for an emergency refill. (typically 3-4 days worth of medication).
5. Your provider will not address medication refill requests during clinic hours while seeing patients. This is not fair to the patients with scheduled appointments.

Office Policies

Urine specimens

At each visit we ask that you come prepared to give a clean-catch urine sample regardless of the reason for visit. This helps in assessing your concerns at the current visit as well as future appointments. If it's easier for you to bring a sample from home please let the clinical staff know that you can be provided with a sterile urine specimen cup. Urine specimens will be required before any testing is performed.

Surgery Scheduling

If notified by a provider that we will be contacting you to schedule surgery please allow 5 business days for the paperwork to be completed and the surgery center be contacted.Once the information is obtained and a surgery date is available we will be contacting you to set up the date and time.If you must leave a message regarding your surgery date please leave no more than 1 message in a 48 hour time span.

Medical Records

According to the fee schedule set forth in the Florida State 455.241 there will be a charge of $1 per page for the first 25 pages requested and $0.25 for each additional page thereafter. An up-to-date medical records release form must be signed and in each patient's chart prior to any record releases being fulfilled. Each records request is subjected to a 5 business day waiting period.

By signing below you agree that you have read and accept the terms and conditions of this page. A copy of this page is available upon request.

Signature of PAtient or Legal Guardian_____

Patient's name_____ Date_____

**We accept all major credit cards for payment, however payments made with a credit card are subject to a 3.5% processing fee. Using cash or check will not incur this charge.

INSURANCE INFORMATION

(Please present Driver's License along with insurance card to the receptionist)

Person Financially Responsible _____ DOB _____ Phone _____

Address _____

Employer _____ Occupation _____ Work phone _____

Primary Insurance _____ Group # _____ Policy # _____

Subscribers' name _____ DOB _____ SS# _____

Relationship to patient _____ Copay _____

Secondary Insurance _____ Group# _____ Policy# _____

Subscriber's name _____ DOB _____ SS#_____

Relationship to patient _____ Copay _____

We will make copies and scan your insurance cards, as a courtesy we will file your insurance.

The above information is true to the best of my knowledge. I have read and understand the Notice of Private Practice presented to me at the front desk. I authorize my insurance benefits to be paid directly to McRichlands, PLLC. I understand that I am financially responsible for any balance my insurance does not pay or denies for any reason. I authorize McRichlands, PLLC or my insurance company to release any information required to process my claims. I understand that authorizations will be obtained but are not a guarantee of payment. I understand that medical transcriptionist may have access to my medical records.

Patient Signature_____ Today's Date _____

Authorization for Release of Medical Information

Date of Request_____ Date of Birth_____

Name of patient_____

Initial___ I hereby authorize Dr. Uzoma K. Nwaubani to obtain my personal health information

This includes but is not limited to: discharge summaries, admission dictation, mental status (psychological evaluations), operative notes, immunizations, outpatient and inpatient summaries related to condition, laboratory reports, radiology, MRI, CT scan, EEG,EKG and any other record related to condition or te treatment and evaluation of care.

Permission to obtain: (Initial) Mental Health Records_____ Drug/Alcohol reports_____
Sexually Transmitted Diseases____

This authorization expires on _____, (if unspecified, 180 days from date of signature).

Signature_____ Date_____

If patient representative, describe representative's authority or relationship to patient_____

RELEASE OF HIV/AIDS INFORMATION

I hereby authorize the release of protected health information pertaining to HIV testing and/or diagnosis and /or treatment of Acquired Immune Deficiency Syndrome (AIDS) solely to Dr.Uzoma K. Nwaubani.

_____ _____
Signature of patient or authorized representative Date

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)
PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how NUWA World may use and disclose protected health information (PHI) about you. The notice contains a Patient Rights section describing your right under the law. Please review our notice thoroughly before signing this Acknowledgement From. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations.

The patient understands that:

- PHI may be disclosed or used for treatment, payment or healthcare operations.
- The practice has a Notice of Privacy Practices and the patient has had the opportunity to review the notice.
- The practice reserves their right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their PHI, but the practice does not have to agree to those restrictions.

I give permission for NUWA World to:

_____ Leave a message regarding an appointment at your designated phone number.

_____ Share medical information with:

Name_____
Relationship_____

Name_____
Relationship_____

I assume responsibility to inform NUWA World of any changes in the above information.

Print Patient Name:	Date:
Signature:	Relationship to patient:
Witness:	

FEMALE CONTINENCE & PELVIC

SURGERY CENTER

MEDICAL HISTORY QUESTIONNAIRE

Name	Date of Birth	Age	Drug Allergies:	Reactions:
Please describe the reason for your visit (chief complaint)				

OBSTETRIC HISTORY

Number of Pregnancies:	Vaginal Deliveries:	Cesarean Deliveries:	Largest Baby Weight:
Forceps or Vaccum ☐ Yes ☐ No	Episiotomy ☐ Yes ☐ No		Laceration/Tear ☐ Yes ☐ No
Degree/Details	Other Complications or Prolonged Labor		

GYNECOLOGIC HISTORY

Gynecologist Name:	Do you experience any of the following? (check ones you have)
Gynecologist Phone Number:	____ Bleeding between periods
Date of last menstrual period:	____ Heavy menstrual periods
Date of last PAP smear: Normal?	____ Pain with periods
Date of last mammogram: Normal?	____ Bleeding after intercourse
Have you ever had a sexually transmitted disease? If yes, when?	____ Pain with Intercourse
Are you sexually active at the present time?	____ "Falling" of pelvic organs or prolapse
Are you using contraception? If yes, what type?	Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	Name of Medication	Dosage How often you take it	How long have you been on the medication
Example - Hypertension	*Tenormin*	*50mg 1 daily*	*2 years*

Reviewed with Patient _____/___/____
Drs Initials & Date

Name	DOB	Date

PAST SURGICAL AND HOSPITAL HISTORY: ☐ None ☐ Yes, if yes
Please describe your past experience with, operations, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY
Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?
Please circle Y or N for each condition (no blanks please ☺)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
Y	N	Asthma	Y	N	Diabetes	Y	N	Stroke
Y	N	Bleeding problems	Y	N	Heart disease	Y	N	Thyroid disease
Y	N	Breast disease	Y	N	High blood pressure	Y	N	Other
Y	N	Breast CA	Y	N	Kidney disease			
Y	N	Cancer (indicate type)						
			Y	N	Adopted			

SOCIAL HISTORY

Marital Status	Drug/Alcohol Use: Yes No	Current Smoke r: ☐ Yes
Single Married Widowed Separated Divorced	Drinks/week	Former Smoker : ☐ Yes # of Cigarettes/day Never Smoked: ☐

Highest Level of Education	Employment (please include job title)

Race: Caucasian African American Hispanic Asian American Other	Ethnicity: Latino / Hispanic Other Refused

REVIEW OF SYSTEMS
Do you have or have you had any serious or chronic medical conditions?
Please Circle Y or N or any condition(s) you have had or that you have currently. (no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight change	Y	N	Fatigue	Y	N			
Eyes:	Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
Ears/Nose/Mouth/Throat:	Ulcers	Y	N	URI (upper respiratory infection)	Y	N			
Cardiovascular:	Chest pain	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
Respiratory:	SOB (short of breath)	Y	N	Wheezing	Y	N			
Gastrointestinal:	Nausea/Vomiting	Y	N	Diarrhea	Y	N	Bloody Stool	Y	N
Musculoskeletal:	Weakness	Y	N						
Integumentary/Skin:	Rash	Y	N						
Neurological:	Seizure	Y	N	Syncope (fainting)	Y	N	Neuropathy	Y	N
Psychiatric:	Depression	Y	N	Anxiety	Y	N			
Endocrine:	Hot flashes	Y	N	Diabetes	Y	N	Thyroid	Y	N
Hematologic/Lymphatic:	Easy bruising	Y	N	Bleeding	Y	N	Adenopathy (Swollen Glands)	Y	N
Allergic/Immunologic:	Seasonal	Y	N	Animal Dander / Foods	Y	N			
Other:									

Patient Signature _____ Date _____

Reviewed with Patient _____/_____/_____
Drs Initials & Date

Please list any allergies you have to any medications and the reaction it caused.	
Medication(s) you are Allergic to:	Reaction:

NUWA

Health Assessment For Women

Name: _____ Date: _____

E-Mail: _____ DOB: _____ Age: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

NUWA

- *Female Hormone Assessment*

Date:_____

Name:_____ DOB:_____

Trying to Conceive Yes No

Uterus Present Yes No

Still Menstruating Yes No

Birth Control Yes No

Type:_____

Smoker Yes No

Endometriosis Yes No

Currently on HRT Yes No

Type:_____

Currently on Thyroid Med Yes No

- Desiccated Yes No
- Synthroid/Equivalent Yes No

Dose:_____

History of Breast Cancer Yes No

Date:_____

Epilepsy or Seizures Yes No

Epilepsy or Seizures Yes No

Fibrocystic Breast Disease Yes No

PCOS Yes No

History of Leiomyoma/Endometrial Polys Yes No

Hashimotos Thyroiditis Yes No

History of Ovarian Cancer Yes No

Date:_____

Pap/Pelvic Exam Yes No

Date:_____

Mammogram Yes No

Date:_____

Understanding of Patient Responsibility

1 . I certify that the information given by me in the New Patient Packet is correct and complete and that I have fully disclosed all information concerning all insurance coverage, which I now have.

2. I understand that all services rendered will be billed to my insurance company. I understand and agree that if the amount of my insurance benefits is insufficient to cover the amount due, I am responsible for payment of the balance. I also understand that should my insurance determine the service to be non covered, I will be responsible for the entire amount. I also understand that I am responsible for any insurance deductibles and co-payments as determined by my insurance.

3. In the event that it is necessary for the physician to retain the services of any attorney in order to collect any amount due from me, I agree to pay all costs of collections incurred by the physician including reasonable attorney's fees and court costs.

4. If at any point there is a change in my insurance coverage, it is my responsibility to inform the office of the change before any services are rendered.

By Signing below you confirm that you have read this policy and understand it.

- It is your responsibility to inform our office of any address or telephone changes.
- Your account is to be kept current-accordingly, all self-payor insurance co-payments, co-insurance & deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, and Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- A returned check will result in a $25.00 service charge and in some cases future payments being required in the form of cash or credit.
- You will only be sent a statement if your balance is $25.00 or more and you will only receive a refund if the credit amount is over $150.00. Refunds will be issued 4-6 weeks from the date requested, IF there are no pending insurance claims.
- There is a $25.00 charge for the completion of paperwork i.e. disability, etc.
- Any unpaid balance older than 90 days may be subject to collections.
- If your account is turned over to a collection agency you will be responsible for any cost incurred in the collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court cost and attorney fees.

_____ _____

Patient Name Date

_____

Patient Signature

A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the D._____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.