Alaska Women's Advanced Pelvic Surgery & Urogynecology LLC
Roger C. Biehl M.D, FACOG
4050 Lake Otis Parkway - Suite 106
Anchorage, AK 99508
(907) 743-8064
FAX (907) 743-8065
www.AlaskaWomensSurgery.com

These Billing forms and your Medical Information on the Patient Portal will take approximately 30-45 minutes to complete. Please take your time and fill out completely, if you have any questions do not hesitate to give our office a call. Thank you.

This packet contains information regarding both you and your visit. It is divided into 5 sections.

Section I Driving directions to our office.

Section II Is your ***Patient Registration Information*** & ***Billing Forms.*** It is very important that you fill out this section and return it to our office on your next visit. It is very important that we receive this information. On page 8 Please make sure to completely fill out all the provider(s)/physician(s) information for those who care for you.

Section III Two forms are to be filled out **ONLY i**f you are being seen for Pelvic Prolapse or Urinary Incontinence. Forms are called:

A.) Quality of life Questionnaire
B.) Bladder health Questionnaire

Section IV Medication form (please list your current up to date medication list)

Section V Instructions on how to enter the Patient Portal and fill out your Personal/Medical History Prior to your first Appointment, ***this is a Secure Encrypted Web Site***

We are looking forward to meeting you!

Sincerely,

Roger C. Biehl MD

IMPORTANT

COMPLETE AND RETURN The Originals
On your scheduled Appointment Date

Please Fax/E-mail/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.
Thank you

By E-mail:
patients@awapsu.com

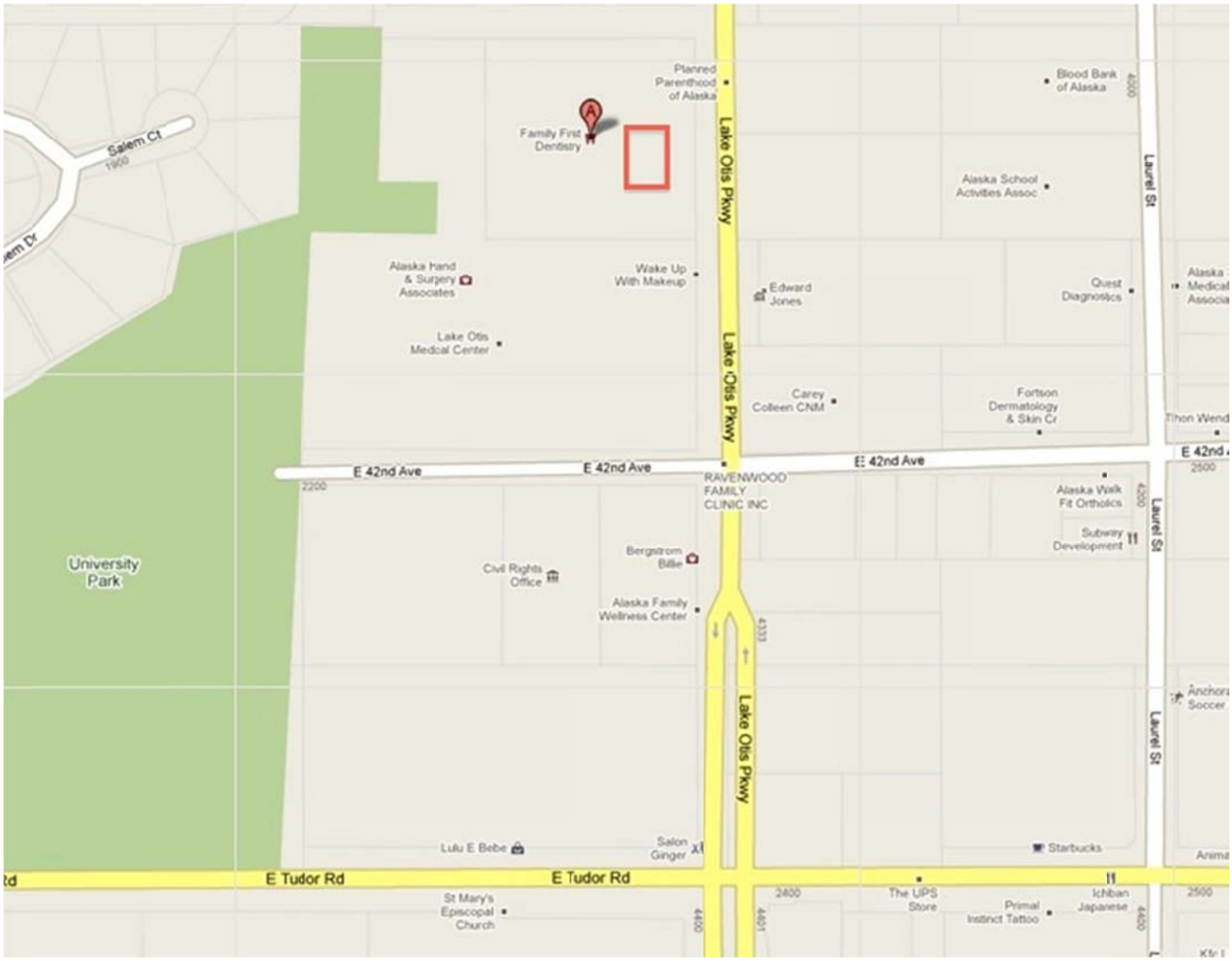
By Fax:
(907) 743-8065

By mail:
Alaska Women's Advanced Pelvic Surgery & Urogynecology LLC
4050 Lake Otis Parkway – Suite 106
Anchorage, AK 99508

If you have had previous Gynecological Surgery or Bladder Surgery, please call your surgeon's office and request that your medical records be faxed to us.

Section I

4050 Lake Otis Parkway Suite 106
Anchorage, AK 99508



Section II

Patient Registration Information

Please complete ALL sections below. Is your condition a result of a work injury? Yes or NO
An auto accident? Yes or NO Date of injury: _____

Patient Personal Information:
Sex: Male Female Marital Status: Single Married Divorced Widowed

Name: _____
Last Name First Name Initial

Street Address: _____

City: _____ County_____ State_____ Zip: _____

Cell phone: _____ Home phone: _____

Driver's License State: _____ Social Security: _____ D.O.B_____

Spouse's Name: _____ Spouse's SSN: _____
Last, First, Initial

Patient/Responsible Party Information: Responsible Party: _____ D.O.B_____

Relationship to Patient: SELF SPOUSE OTHER_____ SSN_____

Responsible Party's Home phone: _____ Work Phone_____

Address :_____(Apt. #) _____ City: _____ State _____Zip:_____

Employer's Name: _____ Phone: _____

Address :_____(Apt. #) _____ City: _____ State _____Zip:_____

Spouse's Employer: _____ Phone: _____

Address :_____(Apt. #) _____ City: _____ State _____Zip:_____

Patient Insurance Information: Name of insured: _____ D.O.B_____

Primary Insurance Company's name: _____ Your Relationship to the Insured _____

Insurance Billing Address: _____ City _____State_____ Zip: _____

Primary Insurance ID number: _____ Primary Insurance Group: _____

Secondary Insurance Company's Name: _____ Your relationship to the Insured: _____

Insurance Billing Address: _____ City _____State_____ Zip: _____

Secondary Insurance ID number: _____ Primary Insurance Group: _____

Patient Referral Information:

Referred By: _____ if referred by a friend, may we thank him/her? YES NO

Name (s) of other physician(s) who care for you: _____

Assignment of Benefits-Financial Agreement:

I hereby give lifetime authorization for payment of insurance benefits to be made directly to AWAPSU and any assisting physicians, for services rendered. I have received and read the Financial Policy, and understand I am financially responsible for the all charge's whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I agree that a photocopy of this agreement shall be valid as the original. No guarantees have been made to me regarding the outcome of this care.

Date: _____ Patient Signature: _____

Patient HIPPA Policy

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Alaska Women's Advanced Pelvic Surgery and Urogynecology LLC, made available our HIPPA polices, which can be obtained in person at our office or from our website at www.AlaskaWomensSurgery.com. The patient acknowledges that by signing this form that they were offered and understood our HIPPA policy.

_____ _____

Patient Signature Date

Patient Billing Instruction Form

Patient Social Security Number #:

_____

Patient Name:

_____

Insurance Policyholder:

_____

Insurance ID#:

_____

Authorization to pay physician:

I hereby authorize _____Insurance Company to mail payment directly to AWAPSU on my behalf. Make checks payable and mail to: (AWAPSU)

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Phone: 907-743-8064
Fax: 907-743-8065

The doctor agrees to accept the medical benefits allowable, and otherwise payable under my insurance policy as payment towards the total charges for service rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to AWAPSU. I understand I am financially responsible for the charges not covered by this assignment.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize AWAPSU to release any information pertinent to the resolution of claims and receiving payment to any insurance company or attorney working on my behalf.

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

_____ _____

Signature Date

FINANCIAL AND PAYMENT POLICY

Thank you for choosing us as your health care provider. We are committed to the success of medical treatment. The following is a statement of our Financial Policy. This form must be completed prior to any treatment.

All patients must complete the patient information sheet before seeing the physician.

DEDUCTIBLE AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE.

FOR PATIENT WITHOUT MEDICAL COVERAGE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.

We must emphasize that as a medical care provider our relationship is with you, not your insurance company. We file the insurance claim as courtesy to you, but all charges are your responsibility. Not every service is a covered benefit in all contacts. Some insurance companies arbitrarily select certain services they will not cover. It is important that you read and understand YOUR health insurance policy and its requirements for coverage, including preauthorization of services. We currently send claims to numerous plans and are not responsible for knowing the requirements of your specific plan.

Private insurance is a contact between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and secondary insurance, " usual and customary" charges, etc; other than to supply factual information as necessary.

Any questions regarding laboratory billing, hospital billing and/or anesthesia billing are to be directed to the hospital.

SURGERY PAYMENTS-MEDICARE/ MEDICAIDE EXCLUDED
A $1,000 (in-state patient)/$1500 (out-of-state patient) deposit is required to schedule your surgery. This is nonrefundable if you choose to cancel.

My method of payment will be: _____ Cash _____Check_____ Credit Card

Signature_____ Date _____

Alaska Women's Advanced Pelvic Surgery and Urogynecology LLC
4050 Lake Otis Parkway, Suite 106
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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____ SS#: _____

I hereby authorize Alaska Women's Advanced Pelvic Surgery and Urogynecology to release information to any medical facility or physician to which I may be referred by this office. I authorize Alaska Women's Advanced Pelvic Surgery and Urogynecology 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 Alaska Women's Advanced Pelvic Surgery and Urogynecology to release records from this office related to my medical history, physical examination or surgery to other physicians who care for me in order 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.

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/Representative Date

PLEASE FILL THIS SECTION COMPLETELY
LIST THE PROVIDERS/PHSYICAINS WHO CARE FOR YOU: IF YOU DO NOT KNOW YOUR PROVIDER/PHYSICANS INFORMATION PLEASE CALL THERE OFFICE FOR THE INFORMATION NEEDED BELOW.

1)	_____ Name	_____ Specialty	_____ Address	_____ Phone number	_____ Fax Number
2)	_____ Name	_____ Specialty	_____ Address	_____ Phone number	_____ Fax Number
3)	_____ Name	_____ Specialty	_____ Address	_____ Phone number	_____ Fax Number
4)	_____ Name	_____ Specialty	_____ Address	_____ Phone number	_____ Fax Number
5)	_____ Name	_____ Specialty	_____ Address	_____ Phone number	_____ Fax Number

Patient Authorization of Release of Medical Records

Please Fill Out Sections A and E only

A. AUTHORIZATION

PATIENT NAME: _____DATE OF BIRTH: _____
SOCIAL SECURITY: _____

B. PHYSICIANS NAMES: _____
_____
_____
_____

The above named Physician are
Hereby authorized to release to:

Alaska Women's Advanced Pelvic Surgery and Urogynecology LLC (AWAPSU)
Roger C. Biehl MD
4050 Lake Otis Pkwy, Suite 106
Anchorage, AK 99508
Phone: 907-743-8064
Fax: 907-743-8065

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

- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Progress Reports
- ☐ Psychiatric Notes
- ☐ History-Physical
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Special Diagnosis Reports
- ☐ Discharge Summary Reports i.e. EKG, EEG, Urodynamics Tests
- ☐ Other

C. USES

This information is needed for the following purpose (must be checked):

- ☐ Continued care by the receiving facility/physician
- ☐ Claims settlement with insurance company
- ☐ Needed to receive aid by the above named agency
- ☐ Legal proceeding or advise
- ☐ Personal use
- ☐ Other

D. DURATION

This authorization is good for a period of 180 days from the date signed

E. I hereby release the Doctor's above and their employees, agents, officers and affiliate from any and all liability, responsibility, claims and damages which may arise as a result of the release of information authorized by your consent of release of Medical Information.

SIGNATURE:

I have read and understand this Consent for Release of medical Information, and have voluntarily and knowingly signed such consent.

_____ _____

Signature Date

Roger C. Biehl, MD
4050 Lake Otis Parkway, Suite 106
Anchorage, AK 99517
907-743-8064
Fax: 907-743-8065

Commitment Guideline

We at Alaska Women's Advanced Pelvic Surgery and Urogynecology are committed to your care and your appointment time is reserved *exclusively* for you. We understand that with life's uncertainties you may need to cancel your appointment. If so, please give our staff a minimum 48 hours notice.

Our doctor dedicates a full hour of patient care for you, our new patient. We are so committed to your healthcare, that when we schedule your first appointment we require the same commitment from you. At that time we will require a credit card number for you- so if you do not keep a scheduled appointment and have not cancelled with at least 48 hours notice, a 100.00 fee will be charged to your credit card. Patients who do not show up to a scheduled follow up visit and do not give at least 48 hours notice during normal business hours will be charged a $75.00 fee. Repeated missed or cancelled appointments may be the basis for termination of service. This enables us to accommodate patient and clients on our waiting list.

Please be advised that the staff of Alaska Women's Advanced Pelvic Surgery and Urogynecology reserves the right to reschedule patients who arrive more the 10 minutes late for their scheduled appointment time.

- **We accept Visa or Master Card**
- **There is a 40.00 charge for all returned checks**

My method of payment will be: _____ Cash _____Check_____ Credit Card

Signature_____ Date _____

Section III

Quality of Life Questionnaire

Has: **Urine Incontinence** and/or **Pelvic Prolapse** affected you're:

	None	Slightly	Moderately	Greatly
Ability to do house chores?	**0**	**1**	**2**	**3**
Physical recreation such as walking Swimming or exercise	**0**	**1**	**2**	**3**
Entertainment activities (movies, concert etc.)	**0**	**1**	**2**	**3**
Ability to travel by car or bus more Then 30 minutes	**0**	**1**	**2**	**3**
Participate in social activity outside the home	**0**	**1**	**2**	**3**
Emotional Health (Nervousness, depression etc.)	**0**	**1**	**2**	**3**
Feeling frustrated?	**0**	**1**	**2**	**3**
Do you experience, and, if so how much Are bothered by:				
Frequent urination?	**0**	**1**	**2**	**3**
Urine leakage related to feeling of urgency?	**0**	**1**	**2**	**3**
Urine leakage related to physical activity, Coughing, or sneezing?	**0**	**1**	**2**	**3**
Small amounts of urine leakage (drops)	**0**	**1**	**2**	**3**
Difficulty in emptying your bladder?	**0**	**1**	**2**	**3**
Pain or discomfort in lower abdomen or genital area?	**0**	**1**	**2**	**3**

Patient Name:_____ Date_____

Bladder Health Questionnaire

1. How often do you urinate during the day?……._____ Times
2. How often do you get up at night to urinate? …….……_____ Times
3. Is the amount of urine you pass: Large Average Small
4. Do you usually have a strong sense of urgency to urinate?.....No Yes
5. Do you have to hurry to empty your bladder when full?.....No Yes
6. Do you ever not make it in time to urinate in the restroom?.....No Yes
7. Can you overcome the sensation of urgency to stop urination .....No Yes
8. Does the sight, sound, or feel of running water cause you to lose urine?.....No Yes
9. Do you leak urine while lying down?.....No Yes
10. When urinating, can you usually stop the stream of urination? ……..…....No Yes
11. Do you ever accidentally wet the bed while sleeping? .....No Yes
12. Do you have difficulty starting your stream of urine ?.....No Yes
13. Do you feel that you completely empty your bladder? .....No Yes.
14. Do you feel you notice dribbling of urine after voiding? ……..No Yes
15. Were you ever catheterized because you were unable to void?.....No Yes
16. Have you ever had your urethra dilated or stretched? …….……...No Yes
17. Do you ever pass blood in your urine? .....No Yes
18. Have you ever passed stones? ……....No Yes
19. . Do you have pain during urination? .....No Yes
20. Have you ever been treated for three or more urinary tract infections? ..... No Yes
21. Have you been treated for a urinary tract infection within the last six months? .....No Yes
22. Do you lose urine while coughing, sneezing, laughing, lifting, jumping, running? ..... No yes
23. Do you find it necessary to use some protection for loss of urine..... No Yes

Section IV

Medication Name	Dosage (mg) & Number of Pills You are Taken at One Time	What Time of Day Medication is Taken	What You are Taking the Medication For	Doctor Who Prescribed the Medication

Please fill out every section completely and bring your medication(s) to your visit

Section V

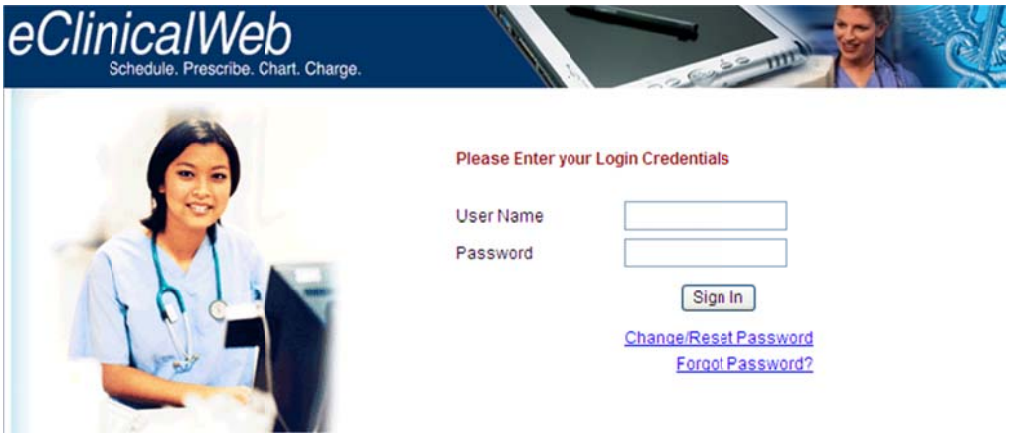
Alaska Women's Advanced Pelvic Surgery & Urogynecology:
Instructions for Patient Portal

Please take your time and fill out completely

If you have any questions Ask US for Help

1. Click On **New Patients** at The Top Of Our Home Page

2. Click on The **Patient Portal**
3. This take you to a website called ***eClinicalWeb***. (shown in image below)



- To Enter this **Secure Website** you will need your

  User Name & Password

- If you do not have a User Name & Password or Forgot Ask the Front Desk or Call Our Office at 907-743-8064
- **The User Name And Password Is Very Important And Allows Access To Your Confidential Medical Information, We Ask That You Not Share It With Anyone**

- If you are having trouble signing in call the office and we will reset a New Password for you.

4. The First time signing onto the portal two consents will Pop UP for:

   1.) EClinical Works

   2.) Alaska Women's Advanced Pelvic Surgery and Urogynecology LLC

When Terms Are Read And Agreed

Click Ok

5. You are now at the Portal Home Page Where You can Communicate with the Doctors office for:

   Appointments | Prescription refills | Lab reports | Referrals
   Billing Statements | Update Personal and Medical Information…

6. On the Left side You will See **Manage (under manage** Click ON the following links)

   1. **Personal Information:** in this selection make sure to choose your Primary Care Provider (PCP). Click on Select PCP. A another way is to begin typing in the **select PCP by last name box** and Click on Look up

      Example: If your PCP is Dr. Wilson. By entering W in the **selecting PCP by last name box**: and clicking on **Look up** it will pop up all the Doctors with the last name beginning with W.

7. **Fill Each Section Out Carefully and Then Click Update then Click OK**
   (under manage Click ON **Additional Information**)

   2. **Additional Information:** In this Selection **Make sure to choose your Personal Pharmacy= Click on Select Pharmacy** then **Click on Look UP** and choose your pharmacy**,** then and Add Any Family or Friends you want us to be able to talk to about your medical History.

Fill Each Section Out Carefully and Then Click Update then Click OK

1. Next On the left side You will see section **Health History Form**

(under Health History Form Click ON the following links)

1. **Medical History**

2. **Surgical and Allergies**

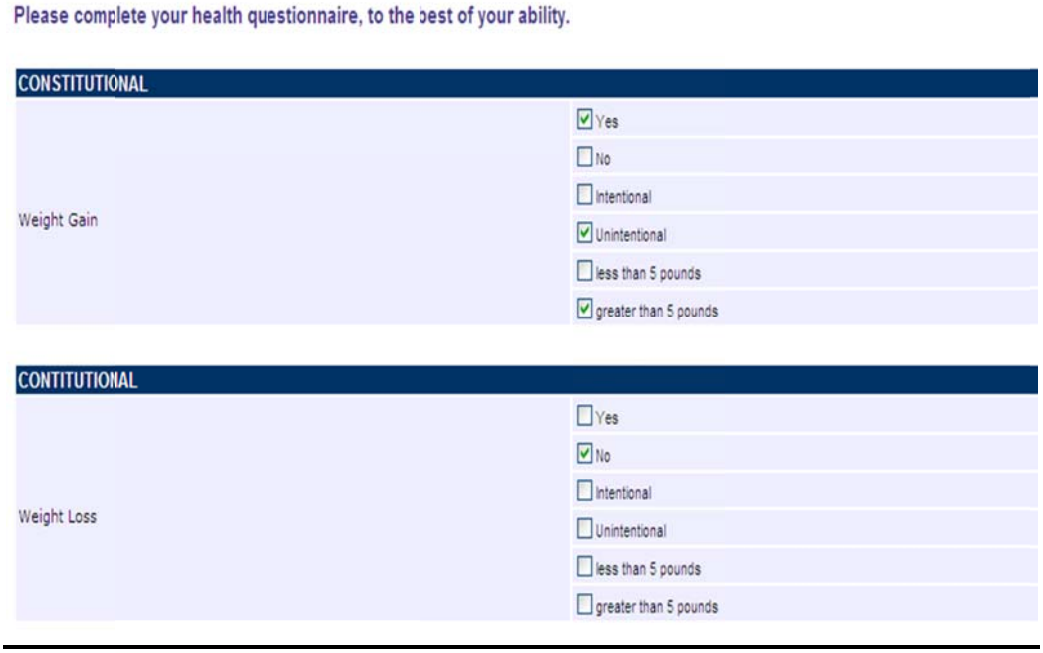
When you Click On these Sections:

- A List of Medical questions will appear **which need to be filled out completely By** Clicking: Yes Or NO

- **IF YOU CLICK NO GO TO THE NEXT SET OF QUESTIONS**

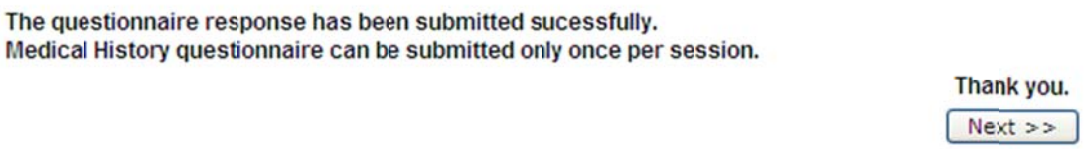
- **IF You Click Yes then Click On Any Other Selections For That Question That Apply**

(Example Below shows you how to fill out the questionnaire)



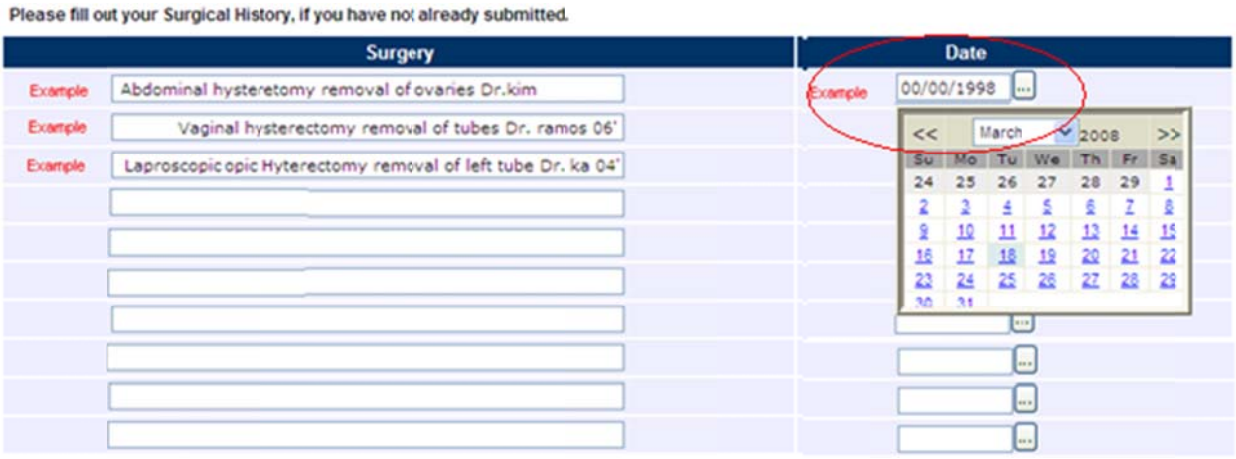
Click On Submit at the End of Each Page

2. At The End of Medical History Click next



3. This will Take you to the **Surgical History and Allergies Information**

<u>Which Needs To Be Filled out Completely</u>



- Under surgical history enter what exact type of Surgery = Laparoscopic Hysterectomy Bilateral Tubes and Ovaries, Surgeon's Name who performed the Surgery, and the Date. If you do not know the Exact date, you may enter the Year Only

(An Example how to enter the **Year Only** is shown Above in the Red Circle Above the Calendar).

4. When Finished Click On Submit

5. A Window will Pop Up (shown in image below) Click Ok

6. **When you are finished** the home page will appear. Please **Make Sure To SIGN OUT**

- THE SIGN OUT is Found on the Top Right Corner of the Home Page

TELEPHONE NUMBERS
(907) 743-8064 Fax (907) 743-8065
Office hours are 8:30 am - 5:00 pm Monday through Friday.
If you have a life-threatening emergency, call 911. If you need to speak to the Doctor on Weekends, Holidays or after hours, call the office for instructions. If you do not receive a response within 20 minutes, call the office again, if No response Call Dr. Biehl's Cell Phone (907) 306-1222. No prescription refills will be approved: after 4:30 pm on workdays, on the Weekend, or on Holidays.