

WOMEN'S PELVIC RESTORATIVE
CENTER

Ginger N. Cathey, M.D.

Kimberly R. Miller-Miles, M.D. • Hilaire W. Fisher, M.D.

Date of Appointment: _____ Time: _____

Dear Patient,

Welcome to our practice. This letter is to confirm your appointment. Please arrive 30 minutes prior to your appointment. Please complete your packet prior to arrival. Late arrival or uncompleted paperwork may result in your appointment being rescheduled. You must visit the check-in desk first. Please bring a copy of your insurance card. All co-payments are due at the time of each visit. If you have any questions or concerns prior to your visit, please do not hesitate to call our office.

The evaluation of pelvic floor dysfunction requires a time commitment. This is not something that can be accomplished in one visit. Usually a minimum of three to five visits are required. Therefore, we have already scheduled your next consultation visit. You may require additional tests prior to this consultation

We have taken great care to try to minimize the number of visits required partly by providing you with the enclosed forms. This allows you to collect the needed medical information at your leisure and reduces the number of visits required to address your condition. We realize the information requested is lengthy and comprehensive. You may find that you need a family member, friend, or information from your doctor to help you complete these documents. PLEASE BRING THE **COMPLETED** FORMS TO YOUR SCHEDULED VISIT. Enclosed you will find:

1. Urinary and prolapse history forms
2. Medical history forms
3. Bladder Diary (instructions attached)

In addition, if you have had previous pelvic surgery, please attempt to bring a copy or have a copy of the OPERATIVE REPORT(S) sent to us from your surgeon or the hospital where your surgery was performed. If you have had recent bladder infections, please provide us with copies of your urine cultures.

We will review these forms with you at your visit. This information is very important for the proper evaluation of your condition. Not having this information may result in a need for additional visits.



What to expect at your first visit:

Because we will perform a physical examination, we suggest that you wear comfortable clothing that is easily removed. At this initial visit, we will perform a pelvic examination that includes a catheterization and measurement of your pelvic organs to help us determine your pelvic support. The examination is not typically any more uncomfortable than other pelvic exams but may take longer to perform. Please do not be distressed if you do not understand our conversation during your examination as we will explain this to you following your exam.

After your examination, we will ask you to dress and we will discuss with you our findings and recommendations. In most instances, we cannot make final treatment recommendations without further testing but we will give you information about your condition for you to take home and read. This will allow you to become more familiar with the information that we may discuss at future visits. This information is your **homework**. It is extremely important that you become familiar with this information in order to understand the implications of your condition as well as risks, benefits and expectations regarding treatment options.

If your circumstances are different and you wish only to have a visit for a discussion consultation without an evaluation, please let our nurse know.

As a courtesy to the staff and to other patients, we ask that you give us 24 hours notice if you must cancel or reschedule your appointment. Additionally, appointments are for a specific time frame. Please respect the time of other patients. If you feel that additional time is needed to discuss your health condition, please arrange for a follow-up appointment.

Again, if you have any questions prior to your visit, please do not hesitate to call. We look forward to meeting you.

Sincerely,

Ginger Cathey, MD



WOMEN'S PELVIC RESTORATIVE
CENTER

Ginger N. Cathey, MD
Urogynecology

www.pelvicrestorativecenter.com
7900 Fannin, Suite 3600
Houston, TX 77054
713-512-7800

Name: _____

Date of Appointment: _____

Date of Birth: _____

Date Completed: _____

Age: _____

Reason for visit: _____

Please provide name, address and **fax** or phone number for the following physicians or healthcare providers:

Who referred you to us? _____

Who is your primary care physician? _____

Who is your regular gynecologist? _____

Do you see any specialists?

Name, address, phone number

Gastroenterologist _____

Cardiologist _____

Urologist _____

Colorectal Surgeon _____

Other _____

History

URINARY INCONTINENCE

- | Yes | No | |
|-------|----|---|
| Y | N | Do you have accidental loss of urine? |
| _____ | | How many months or years have you had leakage of urine? |
| Y | N | Do you wear pads to absorb lost urine? |
| _____ | | If yes, what size pad do you wear? |
| _____ | | How many pads do you wear in a day? |
| _____ | | How many trips to the bathroom do you make during the day from the time you wake up in the morning until the time you go to sleep at night? |
| Y | N | Does an uncomfortably strong need to pass urine wake you up? |
| _____ | | How many times are you awakened during the night after going to sleep by an urge to urinate? |
| Y | N | Does the sound, sight or feel of running water cause you to lose urine? |
| Y | N | Do you lose urine during the act of intercourse at penetration? |
| Y | N | Do you lose urine during orgasm? |
| Y | N | I lose urine during coughing, sneezing, running or heavy lifting |
| Y | N | I lose urine with changes in posture, standing or walking |
| Y | N | I lose urine continuously such that I am constantly wet |
| Y | N | Have you seen a physician for complaints of urine loss? |
| Y | N | Have you taken medicine to prevent urine loss?
If yes, name the medication _____ |
| Y | N | Have you had surgery to prevent urine loss?
If yes, was it done through the vagina?
Was it done through the abdomen? |
| Y | N | Do you notice any dribbling or urine when you stand after passing your urine? |
| Y | N | Do you usually have difficulty starting your urine stream? |
| Y | N | Have you ever required catheterization for the inability to pass your urine? |
| Y | N | Do you always feel that your bladder is empty after passing urine? |
| Y | N | Have you seen any blood in your urine? |

- Y N Do you have any burning with urination?
- Y N Have you had 3 or more urinary tract infections in the last year?

GENITOURINARY PROLAPSE

- Y N Do you have a bulge or mass in your vagina:
- _____ How many months or years have you had this bulge or mass?
- Y N Have you seen a doctor for this bulge or mass in your vagina?
- Y N Have you worn a pessary for this problem?
- _____ If yes, how many months or years have you worn this pessary?
- Y N Have you had surgery in the past for a bulge or mass in the vagina?

FECAL INCONTINENCE

- Y N Do you have accidental loss of solid stool?
- Y N Do you have accidental loss of liquid stool?
- Y N Do you have accidental loss of gas?
- ___yr___mo How long have you had accidental loss of stool or gas?
- Y N Have you seen a doctor for this problem?
- Y N Did the problem with accidental loss of stool begin after childbirth?
- Y N Do you wear protective pads for this problem?
- _____ If yes, what size pad do you wear?
- _____ How many pads do you wear each day?
- Y N Are you able to sense the need to have a bowel movement?
- Y N Are you able to tell the difference between solid stool/liquid stool/gas?
- Y N Do you have a frequent desire to have a bowel movement?
- Y N Have you had surgery for this problem?
- Y N Has there been a change in your bowel habits recently?
- Y N Have you noticed any bright red bleeding with your bowel movements?

Y N Have you noticed black or "tarry" stools?

Y N Are your bowel movements painful?

CONSTIPATION

Y N Do you have constipation?

Y N Do you excessively strain to pass stool more than 25% of the time?

Y N Do you have at least three bowel movements each week?

_____ How many bowel movements do you have each week?

Y N Do you pass hard, small stool?

__yr__mo How many months or years have you had constipation?

Y N Have you seen a doctor for this problem?

Y N Do you use any medication or over the counter products for this?
If yes, what have you used? _____

Y N Have you had surgery for this problem?

Y N Have you ever placed your hand or fingers in your vagina or between
your vagina and rectum to help bring about a bowel movement?

Y N Do you have a feeling of incomplete emptying after bowel movements?

Y N Have you had a colonoscopy? Date: _____ Results: _____

PAST GYN HISTORY

Last pap test (month & year): _____

Have you ever had an abnormal pap smear? Yes No If yes, what year _____

Last mammogram (month & year): _____

Have you ever had an abnormal mammogram? Yes No If yes, what year _____

Y N Have you gone through menopause?
If yes, at what age did you go through menopause? _____

Y N Are your periods regular? How many days do you bleed? _____

Y N Have you had any vaginal bleeding or spotting since menopause?

Y N Have you had a hysterectomy?

If yes, was it done through the vagina or abdomen or laparoscopically ? (Please circle)

Y N Do you have your ovaries?
If yes, both or only one (Please circle)

- Y N Have you had surgery for leakage of urine?
- Y N Have you had surgery for prolapse, "bulges" or "fallen pelvic organs"?

PAST OBSTETRICAL HISTORY

Number of Pregnancies _____
 Number of Vaginal Births _____ Number of C-Sections _____
 Elective terminations _____ Miscarriages _____ Ectopics _____
 Weight of Largest Baby _____

SEXUAL HISTORY

- Y N Sexually Active? If no, why? Please circle
- | | |
|----------------------|--------------------------------------|
| 1. No partner | 4. Painful intercourse |
| 2. Partner factor | 5. Because of bulge or leak symptoms |
| 3. Loss of sex drive | 6. Other |

Partner: Male Female Both (Please circle)

- Y N Contraception? If yes, please circle
- | | |
|----------------------------|----------------------|
| 1. Tubal ligation | 5. Depo-provera |
| 2. Birth control pills | 6. Barrier/ Condemns |
| 3. Intrauterine device IUD | 7. Postmenopausal |
| 4. Partner vasectomy | 8. Other _____ |

- Y N Pain with intercourse: If yes, please circle one or both
- | |
|-------------------------------|
| 1. Near vaginal opening |
| 2. Inside abdomen/pelvic area |

SURGERIES / HOSPITALIZATIONS

Date(s) and reason(s) for surgery/hospitalization:

INJURIES/ILLNESSES

Date(s) and description(s) of injuries and/or illnesses:

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

Y	N	Anemia	Y	N	Heart Murmur
Y	N	Anesthesia Problems	Y	N	Hepatic / Liver Disease
Y	N	Anxiety Disorder	Y	N	High Cholesterol
Y	N	Arrhythmia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	IBS
Y	N	Asthma	Y	N	Immunologic Disorder
Y	N	Bleeding Disorder	Y	N	Kidney Stones
Y	N	Blood Clots/ DVT/ PE	Y	N	MI (Heart Attack)
Y	N	Breast Cancer	Y	N	Migraine Headaches
Y	N	Cancer _____	Y	N	Neurological Disorder__
Y	N	CVA/ Stroke	Y	N	Osteoporosis
Y	N	Chronic Lung Disease	Y	N	Psychiatric Illness _____
Y	N	Chronic Pain _____	Y	N	Seizures/ Epilepsy
Y	N	Congestive Heart Failure	Y	N	Sleep Apnea
Y	N	Coronary Artery Disease	Y	N	Skin Disorder
Y	N	Depression	Y	N	Substance Abuse
Y	N	Diabetes Mellitus	Y	N	STD _____
Y	N	Diverticulitis	Y	N	Renal / Kidney Disease
Y	N	Fibromyalgia	Y	N	Thyroid Disease
Y	N	Gastric Reflux/ Ulcers	Other		
Y	N	Gastrointestinal Disease			_____
Y	N	Glaucoma			_____
Y	N	HIV/ AIDS			_____
Y	N	Hepatitis			_____

FAMILY HISTORY

Has a **blood-related** family member had any of these illnesses:

Yes	No	Don't Know		Relationship
Y	N	?	Diabetes	_____
Y	N	?	Stroke	_____
Y	N	?	Heart disease	_____
Y	N	?	High blood pressure	_____
Y	N	?	Breast cancer	_____
Y	N	?	Colon cancer	_____
Y	N	?	Ovarian cancer	_____
Y	N	?	Prolapse	_____
Y	N	?	Urinary incontinence	_____
Y	N	?	Fecal incontinence	_____

PERSONAL AND SOCIAL HISTORY

Who lives in your home with you? _____
Current marital status: Married _____ Divorced _____ Single _____ Widowed _____

Ethnic Background: Caucasian _____ African-American _____
Hispanic _____ Asian _____ Other _____

Y N Are you employed? If so, occupation: _____

Y N Does your job or a hobby require heavy physical work?

Education

Level of Education: __ Up to 12th Grade __ Beyond 12th Grade Degree: _____

Personal Habits

Y N Smoking Packs per day: _____ Years of use: _____

Y N Alcohol Drinks per day: _____ Drinks per week: _____

Y N Recreational Drug Use What type? _____ How often? _____

MEDICATIONS / PRODUCTS / HERBALS

(Please bring medications in the original bottles for us to review if not recorded)

Name	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____
_____	Symptoms: _____

REVIEW OF SYSTEMS

Please check appropriate box if any of the following apply to you and these are problems that have not been evaluated prior. If checked, please explain.

		Notes
1. Constitutional		
Weight loss	☐	_____
Weight gain	☐	_____
Fever/ Chills	☐	_____
Fatigue	☐	_____
2. Eyes		
Double vision	☐	_____
Spots before eyes	☐	_____
Vision changes	☐	_____
3. ENT/Mouth		
Ear aches	☐	_____
Sinus problems	☐	_____
Sore throat	☐	_____
Mouth sores	☐	_____
Dental problems	☐	_____
4. Cardiovascular		
Chest pain	☐	_____
Difficult breathing on exertion	☐	_____
Swelling of legs	☐	_____
Palpitations of heart	☐	_____
5. Respiratory		
Wheezing	☐	_____
Spitting up blood	☐	_____
Shortness of breath	☐	_____
Chronic cough	☐	_____
6. Gastrointestinal		
Abdominal Pain	☐	_____
Blood in stool	☐	_____
Nausea/vomiting	☐	_____
7. Musculoskeletal		
Muscle weakness	☐	_____
Joint pain	☐	_____
Back pain	☐	_____

REVIEW OF SYSTEMS - Continued

Notes

8. Skin/Breast

Pain in breast	☐	_____
Discharge	☐	_____
Masses	☐	_____
Rash	☐	_____
Ulcers	☐	_____

9. Neurological

Dizzy spells	☐	_____
Seizures	☐	_____
Numbness/ tingling	☐	_____
Trouble walking	☐	_____

10. Psychiatric

Depression	☐	_____
Frequent Crying	☐	_____
Thoughts of Suicide	☐	_____

11. Endocrine

Dry skin	☐	_____
Abnormal thirst	☐	_____
Hot flashes	☐	_____

12. Hematologic/lymphatic

Frequent bruises	☐	_____
Cuts that don't stop bleeding	☐	_____
Enlarged lymph nodes	☐	_____

13. Allergic/immunologic

Allergies	☐	_____
Drug/ Latex allergies	☐	_____

Please list any other concerns you may have regarding your medical history and care.

Completed by: Patient ☐ Family Member ☐ Office Nurse ☐ Physician ☐

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician signature: _____

Revised: 07/31/23 GNC

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Ginger N. Cathey, MD

Urogynecology

7900 Fannin, Suite 3600

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VOIDING DIARY (UROLOG)

THIS CHART IS A RECORD OF YOUR VOIDING (URINATING) AND LEAKAGE (INCONTINENCE) OF URINE. PLEASE READ THE DIRECTIONS CAREFULLY AND COMPLETE THIS SHEET PRIOR TO YOUR FIRST APPOINTMENT. CHOOSE A 24 HOUR PERIOD TO KEEP THIS RECORD WHEN YOU CAN MEASURE EVERY VOID. START THE CHART WITH THE FIRST VOID WHEN YOU GET UP IN THE MORNING.

WE REALIZE THIS MAY BE AN INCONVENIENCE, BUT THE INFORMATION IT PROVIDES IS VERY IMPORTANT IN ASSESSING YOUR BLADDER PROBLEM. WE MAY HAVE TO RESCHEDULE YOUR APPOINTMENT IF THIS DIARY IS NOT AVAILABLE AT YOUR FIRST APPOINTMENT.

YOU MAY MEASURE AMOUNTS IN OUNCES OR IN CC'S-BUT PLEASE INDICATE WHICH YOU ARE USING.

NOTE: 1 CUP = 8 OUNCES = 240 CC'S

1. TIME Record time of every time you void, leak or drink.
2. AMOUNT VOIDED Measure and write down amount of urine voided.
3. ACTIVITY Write down what you were doing when you leaked or lost control of your bladder. Examples are: getting out of a chair, bending over, vacuuming, gardening, doing dishes, taking shower, etc. If you were NOT doing anything active, write down whether you were standing, sitting or lying down.
4. AMOUNT LEAKED Estimate the amount you leaked according to this scale:

1 = damp, few drops only.

2 = wet underwear or pad.

3 = soaked pad or clothing or bladder emptied completely.
5. URGE PRESENT If you had an urge to void before or at the time of the leakage write YES.
If there was NO urge or you didn't realize you were voiding write NO
6. AMOUNT AND TYPE OF FLUID Measure and write down the amount and type of all liquids you drink.

NAME: _____

VOIDING DIARY (UROLOG)

[illegible]

NAME: _____

DATE: _____

Do you experience, and if so, how much are you bothered by:	Not at All	Slightly	Moderately	Greatly
1. Urine leakage related to the feeling of urgency	0	1	2	3
2. (sudden desire to urinate)?				
3. Urine leakage related to physical activity,	0	1	2	3
4. coughing, or sneezing?				
5. Small amounts of urine leakage (drops)?	0	1	2	3
6. Difficulty emptying your bladder?	0	1	2	3
7. Pain or discomfort in the lower abdominal or genital area?	0	1	2	3

Urogenital Distress Inventory-Short form

UDI-6 Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Quality of life due to urinary problems

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

Please draw an "X" across the scale below to best reflect your feelings about your urinary problem.

Pleased

Terrible

--	--	--	--	--	--

Some people find that accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activity, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your...	Not at All	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, house cleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Incontinence Impact Questionnaire- Short Form IIQ-7

Items 1 and 2 = physical activity, 3 and 4 = travel, 5 = social/relationships, 6 and 7 = emotional health

Scoring. Item responses are assigned values of 0 for "not at all," 1 for "slightly," 2 for "moderately," and 3 for "greatly." The average score of items responded to is calculated. The average, which ranges from 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

NAME: _____

DATE: _____

These questions ask about symptoms you may have related to urine leakage. Please circle the number that represents how frequently you experience each symptom.

	0 Never	1 Rarely	2 Sometimes	3 Often
Does coughing gently cause you to lose urine?				
Does coughing hard cause you to lose urine?				
Does sneezing cause you to lose urine?				
Does lifting things cause you to lose urine?				
Does bending cause you to lose urine?				
Does laughing cause you to lose urine?				
Does walking briskly or jogging cause you to lose urine?				
Does straining, if you are constipated, cause you to lose urine?				
Does getting up from a sitting to a standing position cause you to lose urine?				
Some women receive very little warning and suddenly find that they are losing, or are about to lose, urine beyond their control. How often does this happen to you?				
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?				
Do you lose urine when you suddenly have the feeling that your bladder is very full?				
Does washing your hands cause you to lose urine?				
Does cold weather cause you to lose urine?				
Do drinking cold beverages cause you to lose urine?				

MESA Questionnaire

Urge incontinence: maximum total score is 18 based on 6 questions, with a maximum score of 3 for each question.

Stress incontinence: maximum score is 27, based on a question with a maximum score of 3 for each question.

Determine predominance: urge score divided by 18 x 100 vs. stress score divided by 27 x 100

Name: _____

Date: _____

Instructions:

Please answer these questions by putting an **X** in the appropriate box. If you are unsure about how to answer a question, give the best answer you can. While answering these questions, please consider your symptoms over the **last 3 months**. Thank you for your help.

		Not at all	Somewhat	Moderately	Quite a bit
1. Do you usually experience pressure in the lower abdomen?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
2. Do you usually experience heaviness or dullness in the pelvic area?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
3. Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
4. Do you usually have to push on the vagina or around the rectum to have or complete a bowel movement?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
5. Do you usually experience a feeling of incomplete bladder emptying?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
6. Do you ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
7. Do you feel you need to strain too hard to have a bowel movement?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
8. Do you feel you have not completely emptied your bowels at the end of a bowel movement?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
9. Do you usually lose stool beyond your control if your stool is well formed?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4
10. Do you usually lose stool beyond your control if your stool is loose or liquid?	☐ No → <i>Go to next question</i> ☐ Yes→ how much does this bother you? →	1	2	3	4

Name: _____

		Not at all	Somewhat	Moderately	Quite a bit
11. Do you usually lose gas from the rectum beyond your control?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
12. Do you usually have pain when you pass your stool?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
13. Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
14. Does a part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
15. Do you usually experience frequent urination?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
16. Do you usually experience urine leakage associated with a feeling of urgency that is a strong sensation of needing to go to the bathroom?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
17. Do you usually experience urine leakage related to coughing, sneezing, or laughing?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
18. Do you usually experience small amounts of urine leakage (that is, drops)?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
19. Do you usually experience difficulty emptying your bladder?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4
20. Do you usually experience <i>pain</i> or <i>discomfort</i> in the lower abdomen or genital region?	☐ No → <i>Go to next question</i> ☐ Yes → how much does this bother you? →	1	2	3	4



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CLINIC FINANCIAL POLICY

We charge a \$25 fee for missed clinic appointments or appointments cancelled with less than twenty-four hours' notice. We charge \$50 for missed procedure (urodynamics, cystoscopy, etc.) appointments or appointments cancelled with less than twenty-four hours' notice. These charges are not billable to your insurance company and you will be responsible for payment of this charge. Missed appointments often mean that someone else was not able to be seen in a more timely fashion. Please be courteous, cancel or reschedule your appointment as early as possible.

SURGERY RESCHEDULING & CANCELLATION POLICY

Please carefully consider your surgical date prior to scheduling. Your surgery requires the coordination of numerous individuals, including our staff, your surgeon, the anesthesiology department and the hospital. Rescheduling procedures requires significant time and expense, particularly if the operating room goes unused because of a late cancellation. Please be courteous and promptly make our staff aware of any decision to reschedule or cancel your surgery.

-You will be required to pay any fees you may owe for coinsurance or deductibles prior to your surgery. If for some reason your surgery is cancelled and not rescheduled, you will receive a refund for that amount.

-If you reschedule or cancel your surgery within less than 2 weeks' of your surgery, there is a mandatory fee of \$100 and must be paid prior to placing your surgery back on the schedule.

-If you reschedule or cancel your surgery for any reason within less than 72 hours' of your surgery, there will be a mandatory fee of \$200 and must be paid prior to placing your surgery back on the schedule.

Printed Name: _____ Date: _____

Signature: _____

7900 Fannin St., Suite 3600 • Houston, Texas 77054 • 713-512-7800
450 Medical Center Blvd, Suite 410 • Webster, Texas 77598 • 713-578-3860