

NorthShore University HealthSystem
Urogynecology & Center for Pelvic Health
Phone: (224) 251-2374 Fax: (847) 933-3571

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Highland Park ACC
757 Park Avenue West
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Dr. Roger Goldberg
Dr. Peter Sand

Vernon Specialty Suites
225 N. Milwaukee Ave
Specialty Suites
Vernon Hills, IL 60061

Glenbrook Surgical Specialty Suites
2050 Pfingsten Road
Suite 128
Glenview, IL 60025

Dr. Sylvia Botros
Dr. Janet Tomezsko

Gurnee Medical Office
15 Tower Court
Suite 300
Gurnee, IL 60031

Time:

Date:

Dr. Adam Gafni-Kane

Before You Arrive

- Prior to your appointment please call Pre-Registration at (847) 663-8600 to verify your insurance
- Please complete the enclosed forms to help us provide you with the best possible care.
It is important that you BRING THESE COMPLETED forms (and your insurance cards) with you on your first visit.
- Please arrive 15 minutes PRIOR to your appointment to complete additional paperwork
- It is your responsibility to verify with your insurance company and/or PCP if a referral is required. If a referral is required we MUST have it prior to your visit with the doctor. If a referral is required and we do not have one on file, your insurance company may deny coverage for the services rendered. You can have your insurance company and/or PCP fax the referral prior to your appointment to 847-933-3571.

Included in this Packet are the Following Questionnaires:

- Medical History Questionnaire
- Pelvic Floor Questionnaire & Sexual Function Questionnaire

Please Keep in Mind:

- **Come to your first visit with a Partially Full Bladder:** Let the receptionists know if you are uncomfortable on arrival.
- **Initial Examination:** A pelvic examination is usually performed on the first visit. If indicated other bladder testing may also be performed (e.g. urine culture, post-void residual).
- **Canceling or Rescheduling:** In the event you need to cancel or reschedule your appointment, please use NorthShore Connect or call (224) 251-2374 (CFPH), as soon as possible.
- **Late Arrival:** In the event you may be late, please call (224) 251-2374 (CFPH) and let the office know. We cannot guarantee your visit if you arrive more than 15 minutes late.
- **Billing Policy:** All billing is handled by the Professional Business Office at NorthShore University HealthSystem. If your insurer requires a co-payment, you will be required to pay this at the time of service. For billing or insurance questions, please contact the billing office: (847) 570-5000

- **NorthShore Connect:** Allows you to communicate with our office via email, and provides you with computer access to your test results, appointment booking and reminders, and many other benefits. If you have a computer and/or smartphone and are not already enrolled in NorthShore Connect, please visit www.northshoreconnect.org and sign-up or ask the receptionist for login instructions at your visit.

About Our Center

For more than 15 years, our center has been an internationally recognized center of excellence in Female Pelvic Medicine and Reconstructive Surgery, also known as “urogynecology” – a specialty devoted to female bladder, bowel and pelvic conditions. Our goal is to provide you with the most advanced care for these important and often-neglected women’s health problems, while making the process as comfortable and efficient as possible. Our commitment to research provides unique access to cutting edge technologies including medications and new surgical innovations, and our physicians are leading researchers, educators and innovators in this field. Additionally, our technology platform here at NorthShore is second to none: including an advanced data-tracking system that allows us to monitor and constantly improve our outcomes, and also NorthShore Connect which provides every patient with secure email communication with our office and access to your medical results from your computer or smartphone.

Our Urogynecologists

Sylvia Botros, MD – Dr. Botros is Clinical Assistant Professor of Ob/Gyn, and Director of the Urogynecology Fellowship Program. She received her M.D. from The University of Texas Health Science Center and residency in Ob/Gyn at the Lyndon B Johnson Hospital, and a Masters in Clinical Investigation from Northwestern School of Public Health. She completed her fellowship in Urogynecology and Pelvic Reconstructive Surgery at Northwestern University, and has authored several scientific publications.

Adam Gafni-Kane, MD – Dr. Adam Gafni-Kane earned his medical degree from Yale University, and he completed his residency training in OB/GYN at Yale-New Haven Hospital. He completed his fellowship training in Female Pelvic Medicine and Reconstructive Surgery at NorthShore/University of Chicago. Dr. Gafni-Kane is Clinical Assistant Professor of OB/GYN at the University of Chicago. He has published several articles and supervises several research trials within the division.

Roger Goldberg, MD MPH - Dr. Goldberg is Director of Division of Urogynecology at NorthShore, and Clinical Associate Professor of Ob/Gyn at the University of Chicago. Dr. Goldberg completed his B.A. at Cornell University and attended Northwestern University Medical School. He received his Masters in Public Health at Johns Hopkins prior to his residency in Ob/Gyn at Harvard University's Beth Israel Hospital. He has received numerous awards, and is author of numerous articles and two books.

Peter Sand, MD – Dr. Sand received his B.S. and M.D. at Northwestern University. He completed residency in Ob/Gyn at Northwestern University and Fellowship at the University of California, Irvine. Dr. Sand founded this division in 1991, and has directed the Fellowship program. He is a Clinical Professor of Ob/Gyn at University of Chicago, is the recipient of numerous prestigious awards, and has served as President of the International Urogynecologic Association and Associate Editor of the International Urogynecology Journal.

Karen Sasso, RN, APN –As an advanced practice nurse, Karen contributes expertise in many areas of urogynecology, and she sees patients independently for a wide variety of visit types including pelvic floor and behavioral education, medication management, and pessary care.

Janet Tomezsko, MD – Dr. Tomezsko completed her B.S. at Penn State University before attending Hahnemann University. She completed her residency training in Ob/Gyn at Lehigh Valley Hospital. She completed her fellowship at Northwestern University in 1997. Dr. Tomezsko was Chief of Urogynecology at

Northwestern until joining NorthShore in 2009. Dr. Tomezko has published several scientific articles, and has given many lectures throughout the country in the field of urogynecology.

Our Fellows: We are home to a highly regarded training program in Female Pelvic Medicine & Reconstructive Surgery, and our fellows will often be an integral part of your care as they assist your physician. Each of our 3 fellows are fully trained Gynecologists, who spend an additional 3 years in our program. They usually will see you along with your physician at your first visit, and also during testing, follow-up and postoperative care.

NorthShore University HealthSystem
Urogynecology Initial Visit Questionnaire

Name: _____

Date of Birth: _____

Your Primary Care Physician:

Name _____

Address _____

Fax _____

Your Gynecologist:

Name _____

Address _____

Fax _____

Which of the above physicians referred you to our office? _____

Which of the following symptoms are bothering you? Check all that apply:

URINARY

- Urinary incontinence
- Frequent urination
- Nighttime voiding
- Urgency to urinate
- Urinary burning / pain
- Frequent bladder infections
- Difficulty emptying bladder
- Blood in the urine

VAGINAL

- Vaginal /uterine prolapse (bulge)
- Vaginal or vulvar pain
- Vaginal bleeding
- Vaginal discharge
- Vaginal dryness
- Vaginal or vulvar itching

SEXUAL

- Decreased satisfaction
- Painful intercourse

OTHER

- Pelvic pain
- Bladder pain
- Rectal pain
- Abdominal pain
- Back pain

BOWEL

- Accidents involving stool
- Accidents involving gas
- Constipation

Other problem not listed above: _____

Please list the ONE symptom that is MOST bothersome: _____

How long have these problems been present?

- Less than 1 month
- 1-6 months
- 6-12 months
- 1-2 years
- 3-5 years
- 6-10 years
- More than 10 years

Have you had any prior treatments for these problem(s)?

- No prior treatments
- Overactive bladder medication
- Antibiotics for frequent bladder infections
- Kegel exercises
- Physical therapy for the pelvic floor
- Vaginal Estrogen Therapy
- Surgery for urinary incontinence
- Surgery for prolapse (vaginal bulge)
- Medication for pelvic or vaginal pain
- Pessary
- Stool Softeners
- Laxatives
- Botox (for bladder or pelvic symptoms)
- Interstim ("bladder pacemaker")
- Acupuncture (bladder or pelvic symptoms)
- Urethral injections
- Bladder installations (medicine put into the bladder)
- Other: _____

What are your goals in seeking our help (check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> Improve my bladder control | <input type="checkbox"/> Improve my bowel control |
| <input type="checkbox"/> Decrease daytime urination | <input type="checkbox"/> Reduce constipation and difficulty having BM's |
| <input type="checkbox"/> Decrease nighttime urination | <input type="checkbox"/> Improve sexual function |
| <input type="checkbox"/> Reduce urinary (bladder) infections | <input type="checkbox"/> Reduce pain in pelvis, bladder, vagina |
| <input type="checkbox"/> Fix my prolapse (vaginal "bulge") | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Reduce my vaginal prolapse symptoms | |

How often are you urinating (# hours between daytime voids)?

- | | |
|---|--|
| <input type="checkbox"/> Less than 1 hour | <input type="checkbox"/> 4 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> more than 5 hours |
| <input type="checkbox"/> 3 | |

How many times do you wake at night to urinate?

- | | |
|----------------------------|--|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> More than 5 times |
| <input type="checkbox"/> 3 | |

During an average day, how many pads or diapers do you use?

- | | | | |
|----------------------------|------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> >5 |
|----------------------------|------------------------------|------------------------------|-----------------------------|

How often do you leak urine?

- | | |
|--|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About once a day |
| <input type="checkbox"/> About once a week or less often | <input type="checkbox"/> Several times a day |
| <input type="checkbox"/> 2-3 times a week | <input type="checkbox"/> All the time |

How much urine do you usually leak? (whether you wear protection or not)

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> A moderate amount |
| <input type="checkbox"/> A small amount | <input type="checkbox"/> A large amount |

Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal):

0 1 2 3 4 5 6 7 8 9 10

Not at all

A great deal

When does the urine leak? (Please check all that apply)

- Never – urine does not leak
- Leaks before you can get to the toilet
- Leaks when you cough or sneeze
- Leaks when you are asleep
- Leaks when you are physically active / exercising
- Leaks when you stand up after urinating
- Leaks for no obvious reason
- Leaks all the time

Check the one category that best describes how your urinary symptoms are now:

- | | | | |
|---------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
|---------------------------------|-------------------------------|-----------------------------------|---------------------------------|

MEDICAL HISTORY

As an adult have you had any of the following (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Postmenopausal Bleeding |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Anal Incontinence |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Kidney or Bladder Stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Recurrent urinary infections | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Blood Clots | | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Heart Disease | | |
| <input type="checkbox"/> High Blood pressure | | |
| <input type="checkbox"/> Blood in the urine | | |
| <input type="checkbox"/> Any other medical conditions not listed above? Please list here: | | |

OBSTETRICAL HISTORY

Number of Pregnancies _____
Number of Live Births _____
Number of Vaginal Deliveries _____
Number of Cesarean Sections _____

SURGICAL HISTORY

If you're over age 50, have you had a colonoscopy in the past 5 years?

- Yes No

Have you had a Hysterectomy?

- Yes No

If yes: which hospital and when? _____

For what reason? (e.g. "fibroids, bleeding, prolapse"): _____

What type?

- Vaginal Hysterectomy
 Abdominal Hysterectomy
 Laparoscopic or Robotic Hysterectomy

Have you had your ovaries removed?

- Yes No

Have you had previous surgery for urinary incontinence?

- Yes No

If yes: which hospital and when? _____

What type?

- Sling procedure Needle Suspension
 Burch or MMK Urethral Injection

Have you had any previous surgery for pelvic relaxation / prolapse?

- Yes No
 If yes: which hospital and when?

-
- What type?
 Vaginal incision
 Abdominal incision
 Laparoscopic or robotic

List any other operations, and the year performed:

MEDICATIONS

Please list all current medications (including hormones, contraceptives, vitamins) and dosages:

ALLERGIES

Do you have any drug allergies? Y N

Please list which drugs you are allergic to and what happens when you take them:

FAMILY & SOCIAL HISTORY

Have any first-degree relatives had these diseases? If so, please indicate their relationship to you.

Heart Disease _____

Other Cancer (please list type) _____

Stroke _____

Kidney Disease _____

Ovarian Cancer: _____

Blood / Clotting Disorder _____

Breast Cancer _____

Other Family Diseases: _____

Do you smoke:

- No
 Yes

GENERAL REVIEW OF SYMPTOMS

Please check if you've recently had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Muscle aches/pain |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Easy bruising/bleeding |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Anxiety |

Pelvic Floor Distress Inventory Questionnaire

Please answer all of the questions in the following survey. These questions will ask you if you have certain bowel, bladder or pelvic symptoms and if you do how much they bother you. Answer each question by putting an **X** in the appropriate box or boxes. If you are unsure about how to answer, please give the best answer you can. While answering these questions, please consider your symptoms over the last 3 months.

If **YES**, how much does it bother you?

		Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience pressure in the lower abdomen?	Yes No				
Do you usually experience heaviness or dullness in the lower abdomen?	Yes No				
Do you usually have a bulge or something falling out that you can see or feel in the vagina area?	Yes No				
Do you usually have to push on the vagina or around the rectum to have a complete bowel movement?	Yes No				
Do you usually experience a feeling of incomplete bladder emptying?	Yes No				
Do you ever have to push up in the vaginal area with your fingers to start or complete urination?	Yes No				
Do you feel you need to strain too hard to have a bowel movement?	Yes No				
Do you feel you have not completely emptied your bowels at the end of a bowel movement?	Yes No				
Do you usually lose stool beyond your control if your stool is well formed?	Yes No				
Do you usually lose stool beyond your control if your stool is loose or liquid?	Yes No				
Do you usually lose gas from the rectum beyond your control?	Yes No				
Do you usually have pain when you pass your stool?	Yes No				
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	Yes No				
Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	Yes No				
Do you usually experience frequent urination?	Yes No				

(See next page)

Pelvic Floor Distress Inventory Questionnaire

If YES, how much does it bother you?

	Not at all	Somewhat	Moderately	Quite a bit
Do you usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	Yes No			
Do you experience urine leakage related to laughing, coughing, or sneezing?	Yes No			
Do you usually experience small amounts of urine leakage (that is, drops)?	Yes No			
Do you usually experience difficulty emptying your bladder?	Yes No			
Do you usually experience pain or discomfort in the lower abdomen or genital region?	Yes No			

OAB-Q Questionnaire

This questionnaire asks about how much you have been bothered by selected bladder symptoms during the past 4 weeks. Please place a **✓** or **✗** in the box that best describes the extent to which you were bothered by each symptom during the past 4 weeks. There are no right or wrong answers. Please be sure to answer every question.

During the past 4 weeks, how bothered were you by...	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. An uncomfortable urge to urinate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2. A sudden urge to urinate with little or no warning?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3. Accidental loss of small amounts of urine?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
4. Nighttime urination?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
5. Waking up at night because you had to urinate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
6. Urine loss associated with a strong desire to urinate?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Sexual Function Questionnaire (PISQ-12)

The next set of items covers material that is sensitive and personal. Specifically, these questions ask about matters related to your sexual activity in the past month. We realize that for some women, sexual activity is an important part of their lives; but for others it is not. To help us understand how your bladder and pelvic problems might affect your sexual activity, we would like you to answer the following questions from your own personal viewpoint.

While we hope you are willing to answer all of these confidential questions, if there are any questions you would prefer not to answer, you are free to skip them. Please select the most appropriate response to each question. Remember these questions are only relevant to sexual activity in the past month.

In the past month, have you engaged in sexual activities with a partner?

- Yes → complete only Section A below
 No → complete only Section B below

SECTION A: If you have engaged in sexual activity with a partner in the last month

1. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
------------	-------------	----------------	--------------	-------------

2. Do you climax (have an orgasm) when having sexual intercourse with your partner?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
------------	-------------	----------------	--------------	-------------

3. Do you feel sexually excited (turned on) when having sexual activity with your partner?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
------------	-------------	----------------	--------------	-------------

4. On a 5-point scale where "1" indicates very satisfied and "5" indicates not at all satisfied, how satisfied are you with the variety of sexual activities in you current sex life?

Very Satisfied ← → Not at all Satisfied

1	2	3	4	5
---	---	---	---	---

5. Do you feel pain during sexual intercourse?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
------------	-------------	----------------	--------------	-------------

6. Are you incontinent of urine (leak urine) with sexual activity?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
------------	-------------	----------------	--------------	-------------

7. Does fear of incontinence (either stool or urine) restrict your sexual activity?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
------------	-------------	----------------	--------------	-------------

8. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina)?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

9. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

10. Does your partner have a problem with erections that affects your sexual activity?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

6
Not
Applicable

11. Does your partner have a problem with premature ejaculation that affects your sexual activity?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

6
Not
Applicable

12. Compared to orgasms you have had in the past, how intense are orgasms you have had in the past month?

1
Much
more
intense

2
More
intense

3
Same
intensity

4
Less
intense

5
Much less
intense

SECTION B: If you have not had sexual activity with a partner in the last month

1. Do you have a partner at this time?

1
Yes

2
No

2. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

3. On a 5-point scale where "1" indicates very satisfied and "5" indicates not at all satisfied, how satisfied are you with the variety of sexual activities in your current sex life?

Very Satisfied ← → Not at all Satisfied

1

2

3

4

5

4. Does fear of pain during sexual intercourse restrict your activity?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

5. Does fear of incontinence (either stool or urine) during sexual intercourse restrict your sexual activity?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

6. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina)?

1
Never

2
Seldom

3
Sometimes

4
Usually

5
Always

Information for Medicare Recipients about Your Bill for Today's Visit

As a Medicare beneficiary, you may be receiving two bills for today's visit that together represent the total cost of the visit. This is because Medicare has designated NorthShore Medical Group practices as "Provider-Based" sites of care. This designation recognizes that our practices operate as extensions of our hospitals, meeting rigorous standards for quality care, infection control, patient confidentiality and more, while submitting to periodic, unannounced inspections by state and federal authorities.

While Provider-Based designation is not typical or required of physician practices, we believe this status bears testament to our overriding commitment to superior care and continuous quality improvement.

Medicare requires that Provider-Based sites bill patients separately for the professional services provided by physicians (Professional fees), and for the expenses associated with providing the care (Facility/Technical fees), such as office space, nursing, and supplies.

Here are a few important things for you to know about these bills:

- The sum of the two bills you may receive reflects the same total charge that is billed to non-Medicare patients.
- One bill will be from the physician for today's visit and will note the charges for his/her professional services.
- A second bill will be from the NorthShore Hospital Billing Service and will note the facility/technical charges for use of the physician office space, medical supplies, and nursing staff. The bill comes from the NorthShore Hospitals because our offices are designated by Medicare as extensions of our hospitals.
- Both bills may be subject to Medicare's deductible and coinsurance. This means that you may be responsible for coinsurance on both bills. The coinsurance amounts are determined by Medicare and are based on the services performed.
- Typical coinsurance amounts for the most common services provided in our office are listed on the following page:

Service	Hospital Co-Insurance	Professional Co-Insurance	Total Co-Insurance
Office visit or consultation	\$10.00 - \$18.00	\$5.00 - \$30.00	\$15.00 - \$48.00
Nurse visit	\$10.00 - \$18.00	\$0.00	\$10.00 - \$18.00
EKG	\$5.00	\$1.00 - \$6.00	\$6.00 - \$11.00
Flu shot	\$0.00	\$0.00	\$0.00
Welcome to Medicare Physical	\$15.00 - \$20.00	\$15.00 - \$20.00	\$30.00 - \$40.00
Urinary system tests	\$15.00 - \$340.00	\$15.00 - \$80.00	\$30.00 - \$420.00
Nerve conduction tests	\$5.00 - \$15.00	\$10.00 - \$20.00	\$15.00 - \$35.00
Small joint injection or aspiration	\$25.00 - \$30.00	\$10.00 - \$15.00	\$35.00 - \$45.00

- **Please note that the above ranges are only estimates.** Your total responsibility will depend on the actual services received.
- Supplemental insurance benefits you may have may provide additional coverage. Contact your supplemental insurance company if you have questions.

Please refer to the phone numbers listed on your bills for assistance with any additional questions you may have about charges for your care. Should you have questions that Medicare could answer, please contact your Medicare Representative at 800-633-4227.