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The Institute for Female Pelvic Medicine

Referrals

Many health plans require you to obtain a referral from your primary care physician. It is YOUR RESPONSIBILITY to contact your primary care physician and request a referral. If you have not received your referral by noon the day before your appointment, you will be asked to reschedule. If your health plan requires a referral, WE CANNOT PROVIDE SERVICES TO YOU WITHOUT IT.

Initial Appointment

Please be advised that your new patient visit will consist of a provider visit charge as well as diagnostic testing if the provider deems it necessary. Many insurance companies classify these tests as "surgery", but they are tests done in our office.

We have included the procedure codes of some possible diagnostic testing that may occur at your initial visit. Please be advised that there may be additional testing not listed below that your provider may complete at your visit.

UROFLOWMETRY (51741): A test to measure the amount of urine voided and speed of flow.

BLADER SCAN (51798): An ultrasound of the lower abdomen to measure amount of urine in the bladder after voiding.

CYSTOURETHROSCOPY (52000): A camera device within a catheter that is inserted into the bladder to provide pictures inside the bladder. Used to rule out stones, tumors, and cancer of the bladder.

Appointment Cancellation/Rescheduling

Patients who cancel/reschedule an office appointment less than **48 hours** (two business days) in advance or fail to show for an appointment may be charged a fee. The following fees apply: New Patients **$100.00**; Established Patients **$50.00.**

Patients who cancel/reschedule an office procedure less than **three (3) business days** in advance or fail to show for an appointment may be charged a fee of **$200.00.**

Patients who cancel/reschedule surgical procedure less than **ten (10) business days** in advance or fail to show for a surgical procedure may be charged a fee of **$500.00**.

By signing below, I acknowledge I have read, understand, and agree to the above.

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Patient/Authorized Signature Date

Patient Name ______________________________ Date of Birth ____________________