

AVORS MEDICAL GROUP

Antelope Valley Orthopaedic & Rehabilitation Specialists

Alon Antebi, DO
Justin Sherfey, DO

Thomas S. Nasser, DO
Gary Boghossian, DPM

Ajay K. Masih, MD
Tony Smith, DC

Justin Heller, MD
Andrew J. Heller, DPM



Pain Management/Chiropractic Care Patient Forms Packet

- Patient Information
- Insurance Information
- Assignment & Release
- Physician-Patient Arbitration Agreement
- Payment Policy
- Covered CA and Narrow Network Policy
- HIPAA Protected Health Information
- Notice of Privacy Practices Acknowledgment
- DMEPOS Supplier Standards
- Pain Management/Chiropractic Agreement
- Health History Questionnaire

AVORS MEDICAL GROUP
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Patient Information

Date _____ Home Phone _____ Cell Phone _____

Name _____ Sex M F Age ____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Employer _____ Occupation _____ Drivers License # _____

Email _____ Primary Treating Physician/Family Physician? _____

In case of emergency, who should be notified? _____ Phone _____

Race _____ Ethnicity _____ Preferred Language _____

Preferred method of contact Mail Web Message

Insurance Information: Is this a Workers Compensation Claim? No Yes

Primary Insurance _____ ID # _____ Group # _____

Subscriber Name _____ Relationship to patient _____

Cardholder Date of Birth _____ Drivers License # _____

Secondary Insurance _____ ID # _____ Group # _____

Subscriber Name _____ Relationship to patient _____

Cardholder Date of Birth _____ Drivers License # _____

Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with the above insurance listed and assign directly to **AVORS Medical Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be responsible for all collection/attorney fees if my account becomes delinquent. I authorize the use of my signature on all insurance submissions. The above-named physician may use my healthcare information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release is valid until I notify the practice in writing with any changes.

Signature of patient, guardian or legal representative

Date

Printed name of patient, guardian or legal representative

Relationship to patient

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Physician-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intension of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services.

Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledgement that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: **AVORS Medical Group** _____
Date

By: _____
Patient's or Patient Representative's Signature Date

By: _____
Print Patient's Name

Print or Stamp Name of Physician, Medical Group, or Association Name

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records. ©2007 J6815 6/07

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Payment Policy

We appreciate your confidence in our practice and we look forward to participating in your care. We realize that most medical problems are not foreseen; therefore, we wish to advise you of our payment policy.

1. We will file all insurance for your care. You will be responsible for all co-pays, co-insurance and deductibles at the time of visit.
2. All self pay patients will be expected to pay in full on their first visit.
3. All self pay patients and any patient with an outstanding balance over \$250 will be required to apply for CareCredit prior to any payment arrangements being set up. You may elect not to apply for CareCredit, however, you will be responsible for all payments due at the time of service.
4. All self pay patients will be required to pay for elective surgery prior to surgery.
5. We will submit to all patients (2) statements of current patient balances by mail. If we receive no response to these statements, we will begin the collection process immediately. If your account is sent to an outside collection agency, you will be responsible for all collection and legal fees.
6. We encourage you to stay in contact with our office regarding financial issues, as we will attempt to work with you.
7. We accept MasterCard, Visa, American Express, Cash, Check and CareCredit.
8. Returned Check fee is \$25.
9. If you cancel your appointment in less than 24 hours or 'No Show' for an appointment, you may incur a \$25 fee.

I have read and understand the above payment policy.

Patient's Name

Account #

Signature of Patient/Guardian

Date

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Covered CA and Narrow Network Policy

This letter is to educate our patients in the way that your new insurance or your new insurance policy will affect you in our office. **These changes will only affect Anthem Blue Cross and Blue Shield of CA patients.** Although our office is still in-network with “some” of the Blue Cross and Blue Shield plans, we are not in-network with the new Covered CA plans and the Narrow Network plans they are offering.

For our Anthem Blue Cross Covered CA or Narrow Network patients, unfortunately at this time our office will “not” be able to accept insurance or schedule appointments at this time. The reason that we will be unable to see patients at this time is because currently the Blue Cross’ system is unreliable in providing accurate information regarding whether or not a plan is a PPO or an EPO. As a result we are seeing patients who should have out-of-network benefits with a PPO plan, but do not because their plan is truly an EPO. This is causing an unexpected cost to patients that they may not be prepared for. Blue Cross is also inconsistent with the labeling of their insurance ID cards, showing whether or not the plan is a Covered CA plan or a Narrow Network plan. Since we currently cannot rely on the information they are producing and we are not in-network with their new Covered CA and Narrow Network plans, we will “not” be seeing patients with these plans.

For our Blue Shield Covered CA and Narrow Network patients, we will be able to accept your insurance at this time, however, you will be charged for what Blue Shield allows for a service at the time of your visit. You will be charged the rate that our current contract with Blue Shield allows and not the 30% fee reduction that the new Covered CA and Narrow Network plans allow. The reason for this is because Blue Shield is processing our claims as out-of-network and mailing the payments to the subscriber of the insurance. If you want an explanation as to what your out-of-network benefits are, you should contact your insurance for the most accurate explanation.

AVORS Medical Group apologizes for any inconvenience that this is causing you, but in order to provide the highest level of care without compromising patient care both physically and financially, this is the policy that we have to implement at this time.

If you have any other questions regarding this policy, you may speak with the billing department for further explanation. Thank you for your understanding and patience during this transition period.

Patient Name

Signature

Date

HIPAA Protected Health Information

In general the Health Information Patient Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on use or disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number the patient has provided on the Patient Information sheet.

Please verify your phone numbers and complete the following:

Home Telephone (_____) _____ - _____

- Okay to leave message with detailed information.
- Leave message with call-back number only.

Cellular Telephone (_____) _____ - _____

- Okay to leave message with detailed information.
- Leave message with call-back number only.

Work Telephone (_____) _____ - _____

- Okay to leave message with detailed information.
- Leave message with call-back number only.
- Okay to fax to (_____) _____ - _____.

Written Communication (_____) _____ - _____

- Okay to mail to my home address:

- Please mail to another address

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for use or disclosures made pursuant to any authorization requests by the individual.

Record of Disclosures of Protected Health Information

I, _____, authorize the office of **AVORS Medical Group** to contact the following person(s) in regard to my medical information.

Name/Relationship

Telephone Number

Name/Relationship

Telephone Number

Patient Name/Date of Birth

Patient Signature

Today’s Date: _____

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Notice of Privacy Practices Acknowledgment

- I wish to receive a copy of the Notice of Privacy Practices at the time of my signature below.
- I decline to receive a copy of the Notice of Privacy Practices at this time. I understand I can obtain a copy at any time per my request.

Name

Date of Birth

Signature

Date

DMEPOS Supplier Standards

DMEPOS = Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Supplier = **AVORS MEDICAL GROUP**

CMS = Centers for Medicare and Medicaid Services

Patient Name: _____ Date of Birth: _____

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any change to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections and ascertain the supplier's compliance with these standards. The supplier location must be accessible to the beneficiaries during reasonable business hours and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product-related liability and completed operations.
11. A supplier must agree to not initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral orders unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish the CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited, in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 CFR § 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice with certain Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

Patient Signature

Today's Date

Copy to Patient _____

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Pain Management/Chiropractic Care Agreement

This is an agreement between (patient name) _____ and **AVORS Medical Group** regarding my pain management/chiropractic care. The purpose of this agreement is to establish clear conditions for the prescription and use of pain controlling medications prescribed by my pain physician.

I understand that there are alternative treatments which include but are not limited to: physical therapy/occupational therapy (PT/OT), home exercises and modalities, devise trials, injections, non-opioid pharmacotherapy, holistic treatment, pain counseling, chiropractic care, and acupuncture.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of narcotics increases certain risks, which include but are not limited to:

Addiction

- Allergic reactions, overdose, and/or fatal complications
- Breathing problems
- Drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Development of tolerance

I agree to the following guidelines:

1. I will take my medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (see #2)
2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will only be provided during regular office hours.
3. I will obtain ALL of my prescriptions through **AVORS Medical Group** and will fill ALL of my prescriptions at (pharmacy name) _____. In an acute emergency, another provider may prescribe medications for me. If this occurs, I will notify **AVORS Medical Group** as soon as possible.
4. I will submit to random urine and/or blood tests if requested by my physician or nurse practitioner to access my compliance.
5. I agree to see **AVORS Medical Group** for ongoing case management and will keep regularly scheduled appointments as long as I am taking any narcotic medication.
6. If I do not follow these guidelines, I understand that my treatment may be terminated.

I understand and consent to the above requirements for continued treatment. I will discuss the risks, benefits, and alternatives to narcotic treatment with my provider. I will have an opportunity to ask questions and receive answers to those questions to my satisfaction.

Patient's Name

Date

Patient's Signature

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Health History Questionnaire Pain Management/Chiropractic Care

Patient's Name _____ MR # _____

Today's Date _____ Date of Birth _____ Age _____

Referring Physician _____

Please describe the problem you are being seen for (if this is a visit following discharge from a hospital, please include your date of discharge and diagnosis).

Did this problem/pain come on suddenly gradually

Please mark how the following affects your problem or pain.

	Better	Worse	No Change		Better	Worse	No Change
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying Flat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have any back pain, please answer the following question:

1. Do you have pain rising from a seat/seated position?..... No Yes
2. Do you have pain with coughing or sneezing?
3. Do you lean on a shopping cart at the store to relieve your back pain? ..
4. Are you awakened from sleep due to pain?
5. Do you have morning stiffness?
6. Do you have fevers or sweats accompanying your pain?

Health History Questionnaire
Pain Management/Chiropractic Care (continued)

What medications have you tried for this problem, if any? Please include any over-the-counter or herbal supplements.

Were any of these effective? If so, please describe.

What is the character of your pain? For example: is it dull, aching, sharp, throbbing, or “pins and needles.”

If you are experiencing pain, please rate your pain on a scale of 0-10, with 0 being no pain and 10 being the most.

Pain at best (0-10) _____ Pain at worst (0-10) _____

How long has this been going on? _____ Is this a work-related injury? No Yes

Have you had any previous therapy for this problem, including injections or treatments? If so, please describe.

Have you seen a physician previously for this? If so, who?

Health History Questionnaire
Pain Management/Chiropractic Care (continued)

Have you had any recent special testing done for this problem? If so, please describe (For example: MRI, CT scan, bone scan, EMG, etc.).

Please list all current medications including over-the-counter medications, vitamins, and supplements.

Please list all drug allergies. _____

Family Medical History

	You	Family	Never
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or Urine Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems (Asthma, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (Stroke, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please clarify any You or Family positives.

Health History Questionnaire
Pain Management/Chiropractic Care (continued)

List any past surgeries.

Social History

Do you live in a one or two story home? one story two story

How many stairs to enter? _____ Who do you live with? _____

Do you use tobacco? No Yes If yes, how many packs per day? _____

Do you drink alcohol? No Yes If yes, how much per day? _____

Do you any illegal drugs? No Yes If yes, what? _____

Are you currently employed? No Yes If no, when was your last day of work? _____

Health History Questionnaire

Pain Management/Chiropractic Care (continued)

Review of Systems

Any unmarked boxes are otherwise negative.

Constitutional Symptoms

- No Yes Weight gain or loss
Amount _____
Time span _____
- No Yes Fever, Chill, Night sweats

Skin

- No Yes Change in color
- No Yes Wounds
- No Yes Itching
- No Yes Temperature changes
- No Yes Change in nails
- No Yes Easy bleeding/Bruising
- No Yes Lymphatic problems

Head & Neck

- No Yes Headache/Facial pain
- No Yes Neck pain/Stiff neck

Eyes

- No Yes Change in vision
- No Yes Light sensitivity/Pain
- No Yes Visual loss

Ears

- No Yes Loss of hearing
- No Yes Ringing in ears
- No Yes Recurrent infections
- No Yes Vertigo/Dizziness

Nose

- No Yes Change in ability to smell
- No Yes Bloody noses
- No Yes Snoring
- No Yes Frequent colds

Mouth & Throat

- No Yes Change in taste
- No Yes Sore throat
- No Yes Difficulty swallowing
- No Yes Difficulty speaking
- No Yes Voice change

Psychiatric

- No Yes History of delusions
- No Yes Hallucinations
- No Yes Depression
- No Yes Anxiety
- No Yes Hospitalization for above

Gastrointestinal

- No Yes Abdominal pain
- No Yes Nausea/Vomiting
- No Yes Peptic Ulcer disease
- No Yes Rectal bleeding
- No Yes Black tarry stools
- No Yes Heartburn/Acid reflux
- No Yes Diarrhea/Constipation

Cardiovascular

- No Yes Chest/Jaw/Arm pain
- No Yes Palpitation
- No Yes Shortness of breath
 At rest With exertion
- No Yes Lightheadedness
- No Yes Passing out
- No Yes Ankle swelling
- No Yes Fatigue
- No Yes Cold extremities

Respiratory

- No Yes Cough
 Productive Dry Bloody
- No Yes Night sweats
- No Yes History of asthma/wheezing
- No Yes Bronchitis
- No Yes Pneumonia

Musculo-Skeletal & Neurologic

- No Yes Muscle problems
 Pain Atrophy
- No Yes Joint problem
 Swelling Heat
- No Yes Bone problem
 Fracture Deformity
- No Yes Numbness or tingling
- No Yes Weak in arms or legs
- No Yes Balance problems
- No Yes Memory problems
- No Yes Trouble concentrating

Genito-Urinary

- No Yes Frequency
- No Yes Urgency
- No Yes Hesitancy
- No Yes Dribbling
- No Yes Incontinence
- No Yes Blood in your urine
- No Yes Inability to completely empty bladder