Associates in Central Ohio OB/GYN, INC

575 Westar Crossing, Suite 102 • Westerville, OH 43082 • (614) 839-5555
6482 East Main Street, Suite B • Reynoldsburg, OH 43068 • (614) 856-0327
acoog-obgyn.com

Dear _____,

We are happy that you have chosen us for your Gynecological care. To ensure that your visit is prompt as possible, we have enclosed your registration paperwork. Please complete and present it to the receptionist upon arrival to your appointment. In addition, we also require that you present your insurance card and co-pay, deductible, or coinsurance due at the time of service. If you have had a recent insurance change and have not yet received a card from your insurance carrier, you must contact our office prior to your appointment so that we may advise you of the information required prior to being seen. We ask that you arrive for your appointment 30 minutes early to complete the registration process. In order for our physicians to maintain a timely schedule and to keep our patients' wait time minimum, we ask that you please read the list of office policies below. If you fail to comply with any of these items, you will be asked to reschedule.

- ALL PAPERWORK MUST BE FILLED OUT COMPLETELY.
- YOU MUST HAVE YOUR INSURANCE CARD AND ANY REQUIRED CO-PAY, DEDUCTIBLE, OR COINSURANCE AT THE TIME OF YOUR APPOINTMENT.
- YOU MUST BE ON TIME FOR YOUR APPOINTMENT. IF AT ANY TIME YOU HAVE A CHANGE OF ADDRESS, EMPLOYMENT, OR INSURANCE WE ASK THAT YOU ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME IN ORDER TO UPDATE THIS INFORMATION
- IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, YOU MUST OBTAIN THIS PRIOR TO YOUR APPOINTMENT. IF YOU DO NOT HAVE THE PROPER REFERRAL, YOU WILL BE ASKED TO RESCHEDULE.
- PLEASE GIVE 24 HOURS NOTICE TO CANCEL OR RESCHEDULE AN APPOINTMENT. FAILURE TO DO SO MAY RESULT IN A NO-SHOW CHARGE BEING APPLIED TO YOUR ACCOUNT.

We look forward to meeting you!

Sincerely,

The Providers of Associates in Central Ohio OB/GYN

Associates in Central Ohio OB/GYN, Inc. (ACOOG)

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☐ New patient ☐ Established patient

Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Marital Status

Preferred method for appointment reminders (Check one): Call ☐ E-mail ☐ Text ☐ Primary Care Physician: _____

Social Security Number: ___ - ___ - ____ Date of Birth: ___ / ___ / ____

Emergency Contact

May we release protected health information to this individual? ☐ YES ☐ NO

Last Name First Name MI

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Relationship

Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ Other

Other (Please Specify): _____ Effective Date: ___ / ___ / ____

Name of policy holder: Last Name First Name Middle Initial / Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_____) _____ - _____

Social Security Number of Policy Holder: ___ - ___ - ____ Policy Holder Date of Birth: ___/___/____

Insurance Identification Number: _____ Group Identification Number: _____

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____

Name of Employer (Company Name) Occupation

Phone Number: (___) ___ - ____

Address

City State Zip Code

Medications

List all medications you take, prescription and nonprescription, and their dosage: ☐ No medications

	Medication	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medication Allergies

Please list medications that you are allergic to and/or check any of the following foods:

	Medication/Food	Reaction	Medication/Food	Reaction
1				
2				
3				
4				

Do you have a Latex Allergy? YES NO

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

☐ Alcohol dependence	___/___/___	☐ Diabetes Type I	___/___/___	☐ Kidney stones	___/___/___
☐ Allergies	___/___/___	☐ Diabetes Type II	___/___/___	☐ Kidney disease	___/___/___
☐ Anxiety	___/___/___	☐ Diarrhea	___/___/___	☐ Liver disease	___/___/___
☐ Arthritis	___/___/___	☐ Disc degeneration	___/___/___	☐ Migraines	___/___/___
☐ Asthma	___/___/___	☐ Drug Dependence	___/___/___	☐ Obesity	___/___/___
☐ Blood clots	___/___/___	☐ Emphysema	___/___/___	☐ Osteoarthritis	___/___/___
☐ Broken bones	___/___/___	☐ GERD	___/___/___	☐ Osteoporosis	___/___/___
☐ Bronchitis	___/___/___	☐ Gallbladder stones	___/___/___	☐ Rheumatoid Arthritis	___/___/___
☐ Cancer	___/___/___	☐ Goiter	___/___/___	☐ Sciatica	___/___/___
Type: _____	_____	☐ Heart attack	___/___/___	☐ Seizures/epilepsy	___/___/___
_____		☐ Heart disease	___/___/___	☐ Sinusitis	___/___/___
☐ Chronic fatigue syndrome	___/___/___	☐ Hepatitis	___/___/___	☐ Sleep apnea	___/___/___
☐ Circulatory disease	___/___/___	☐ High blood pressure	___/___/___	☐ STD _____	___/___/___
☐ Colitis	___/___/___	☐ High cholesterol	___/___/___	☐ Stomach ulcer	___/___/___
☐ COPD	___/___/___	☐ Insomnia	___/___/___	☐ Stroke (CVA)	___/___/___
☐ Crohn's disease	___/___/___	☐ Irregular heart rhythm	___/___/___	☐ Thyroid disease	___/___/___
☐ Depression	___/___/___	☐ Irritable bowel (IBS)	___/___/___	☐ Tuberculosis	___/___/___

☐
Other_____

Health Maintenance

Exams	Date of Last	Results	Vaccines	Date of Vaccine
Bone Density			**Flu Vaccine**	
Breast Exam			**Tetanus Vaccine (Tdap)**	
Colonoscopy			**HPV (Gardasil) #1**	
Gyn Exam			**HPV (Gardasil) #2**	
Mammogram			**HPV (Gardasil) #3**	
Pap Smear			**TB Screen**	
Other			**Covid Vaccine**	
			Other	

Obstetrical History:

How many times have you been pregnant? (Include miscarriages, abortions, etc.) _____

How many children have you given birth to? _____

Date	Sex	Weight	Weeks at Delivery	Labor Length	Delivery Type	Complications

Surgical History

Date	Surgery Type	Dr.'s Name	Hospital

REVIEW OF SYMPTOMS

Please indicate if you currently or frequently have any of the following: (circle all that apply)

Menses: **Age started menstrual cycle?** _____

LMP ____/____/____ Regular Irregular Absent

Flow: Heavy Light Normal Spotting

Frequency: < 28 days >28 days Every 28 days
Constant Decreased Increased

Painful Periods? YES NO

Heavy Periods? YES NO

Breast:

Discharge? YES NO Left Right

Pain? YES NO Left Right

Lumps? YES NO Left Right

Do you do self-Breast Exams? YES NO

Postmenopausal: **YES** **NO** **Age:** _____ **Year:** _____

Postmenopausal type: Bilateral oophorectomy Chemo induced Drug Induced
Hysterectomy W/BSO Natural Premature

Hormone Replacement Therapy: Estrogen only Estrogen/Progesterone Progesterone only Raloxifene

Menopausal Symptoms: None Hot flashes Insomnia Night Sweats Vaginal Dryness

Additional Symptoms: **No associated symptoms**

Abnormal bleeding	Depression	Nocturia (Urinating at night)	Urinary Urgency
Anxiety	Difficulty falling asleep	Pain with sex	Vaginal Discharge
Change in mole	Fatigue	Sexual dysfunction	Vaginal Itch
Change in weight	Heart/Lung Issues	Sleep disturbances	Other _____
Decreased Libido	History of Infertility	Urinary Incontinence	Other _____

Family History

Please check if any family members have had any of the following conditions. Indicate the affected member, the age of onset and/or if it was the cause of death.

☐ **Adopted**

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
☐ ADD/ADHD						
☐ Alcoholism						
☐ Alzheimer's disease						
☐ Asthma						
☐ Blood Clots						
☐ Heart disease/Heart Attack						
☐ Heart disease before age 50						
☐ Cancer						
Type: _____						
☐ Depression						
☐ Developmental delay						
☐ Diabetes						
☐ High cholesterol						
☐ High Blood Pressure						
☐ Inflammatory Bowel Disease						
☐ Kidney disease						
☐ Liver Disease						
☐ Mental illness						
☐ Migraines						
☐ Obesity						
☐ Osteoporosis						
☐ Seizures/epilepsy						
☐ Stroke (CVA)						
☐ Thyroid Disorder						
☐ Other:						

☐ Family History of: _____

Social History

Do you use tobacco? ☐ Yes ☐ No ☐ Former Type of tobacco used? _____/_____

Packs per day? _____ Years smoked? _____ Year Quit? _____

Other Tobacco units per day (cans, cigars, etc)? _____

Units per day? _____ Years used_____? Year Quit? _____

Do you drink caffeine? ☐ Yes ☐ No Type? _____ Amount Daily? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Former Year Quit? _____

Type? _____ How much per week? _____

Amount? _____ Last Drink? _____

Do you or have you used illegal Drugs: ☐ Yes ☐ No Type? _____ Amount Daily? _____

Years Used: _____ Year Quit: _____

Marital Status: Single Married Divorced Separated Widow Other

Are you sexually active? Yes No

Gender Identity: _____ **Preferred Pronouns:** She/Her/Hers He/Him/His They/Them/Theirs Other

Sexual Orientation: Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Other:_____

Previous Blood Transfusion: Yes No If Yes, Year _____

Any History of Sexual Abuse: Yes No

Any History of Domestic Violence: Yes No

Religious Preference: _____ **Ethnicity:** _____

Preferred Pharmacy:

Pharmacy: _____ Phone Number: _____

Address: _____

Pharmacy: _____ Phone Number: _____

Address: _____

Patient Name: _____

Confidential Communications

I hereby request to receive confidential communication from ACOOG in the following manner:

1. Telecommunications/E-mail:
   - ☐ Web enable this account using ACOOG's patient portal.

   Please leave messages as follows (check all that apply):
   - ☐ Home Phone **Brief or Extended** ☐ Cell Phone **Brief or Extended**
   - ☐ Work Phone **Brief or Extended**
2. Postal Communications:

   Please mail my protected health information to me at (select only one):

   ☐ Mailing Address on file ☐ Other as follows

   Address:_____ City:_____ State:_____ Zip:_____
3. Emergency contact as listed on page one (1) of this form
4. Additional Contact - In your absence who can we leave protected health information with?

   Name:_____ Relation:_____ Phone # _____

Notice of Privacy Practices

I understand ACOOG will notify me if ACOOG is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency situation. I have received the Notice of Privacy Practices at Associates in Central Ohio OB/GYN, Inc. (ACOOG). ☐ **Yes** ☐ **No Initials** _____

Insurance Assignment and Acknowledgement:

I understand my insurance carrier can choose to assign benefits to Associates in Central Ohio OB/GYN, Inc. or my insurance carrier may make payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly by me insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information for each visit. We file claims directly to primary insurance only (exception: secondary government plans). Upon request we will provide a claim form for you to file with your secondary insurance carrier. If you are required to have a referral for your appointment, please be sure to bring it to your appointment.

If we are not participants in your insurance plan, upon request, our billing office will provide you with an itemized claim form to file with your insurance carrier for reimbursement. However, payment is expected in full at time of service. ***Billing#614-923-0153.***

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder for medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.

I acknowledge I was given an opportunity to decline to have my information exchanged through the Offerings which rely upon the Record Locator Service ("opt-out"). If I choose to opt out, all notifications will be turned off.

We require a 24 hour cancellation notice. Failure to due so will result in a $52 no show fee after first occurrence. If you fail to make payment in full for services rendered to you, your outstanding balance will be placed with our collection attorney.

By signing below, I certify I will pay to Associates in Central Ohio OB/GYN, Inc. any co-payments, co-insurance, deductibles or non-covered services. I understand the ACOOG does not accept post-dated checks. I will immediately pay to Associates in Central Ohio OB/GYN, Inc. any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance for my failure to provide that appropriate insurance information for billing.

_____	_____	_____
Patient Printed Name (if 18 and older)	Patient Signature (if 18 or older)	Date Signed
_____	_____	_____
Guarantor Printed Name (if applicable)	Guarantor Signature (if applicable)	Date Signed

Associates in Central Ohio OB/GYN, Inc.

The doctor and patient are desirous of entering into and/or maintaining a positive physician/patient relationship that focuses on quality patient care and open lines of communication. The parties to this agreement shall agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the physician/patient relationship, the patient agrees to submit in writing to Associates in Central Ohio OB/GYN, Inc., any dispute, controversy or disagreement arising out of or relating to the physician/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to Associates in Central Ohio OB/GYN, Inc., the parties shall use negotiation in an attempt to reach a voluntary resolution of their differences.

2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter shall be submitted to mediation in accordance with the Associates in Central Ohio OB/GYN, Inc. Rules of procedure.

   Mediation is a process in which a neutral third party helps the doctor and the patient discuss the issues that have arisen between them with the ultimate goal of resolving any problems. Either party is entitled to seek legal representation at any time, but Associates in Central Ohio OB/GYN, Inc. wishes to provide the patient with this opportunity to settle any problems that may have arisen without the need to incur additional cost and fees.

   These Mediation Rules of Procedure provide in part that:

   - The patient is not required to reach a resolution in mediation.
   - The mediator (or co-mediators) will be a neutral third party who is trained in mediation.
   - All mediation sessions are considered confidential as defined in Ohio Revised Code 2317.123.
   - The costs of mediation will be paid by Associates in Central Ohio OB/GYN, Inc.
   - The date, time and place of any mediation session shall be scheduled by the mediator in consultation with the parties.
   - The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
   - Any agreements reached by the parties shall be in writing and signed by both parties.
   - Parties considering mediation should remember by signing this agreement they agree to make a good faith effort at mediation prior to pursuing litigation. Any decisions may affect their legal rights. Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

It is the goal of Associates in Central Ohio OB/GYN, Inc. that all physicians and patients engage in a cooperative approach to ensure quality healthcare and that any conflicts that may arise between them will be resolved in the same cooperative style through mediation.

Patient _____ Date _____ Doctor _____ Date _____

Risk assessment for hereditary cancer syndromes

Patient name: _____ Patient date of birth:_____

Have you had BRCA or other cancer genetic testing in the past (check one)?

_____ Yes (date_____) If so, you don't have to continue filling out this form.

_____No. Please continue.

For the following questions, please consider the following individuals: Yourself, mother, father, sister, brother, cousin, aunt, uncle, grandparents, niece, nephew, great grandparents.

Family history of Cancer			**Mother's side (who and what age)**	**Father's side (who and what age)**
Yes	No	Example	Self age 30, Aunt age 40, cousin age 20	
Yes	No	Ovarian Cancer		
Yes	No	Breast cancer **before age 50**		
Yes	No	Two or more breast cancers on the same side of the family		
Yes	No	Male breast cancer		
Yes	No	Ashkenazi Jewish ancestry **AND** breast, ovarian or pancreatic cancer		
Yes	No	Colorectal or uterine (endometrial cancer) **before age 50**		
Yes	No	Three or more colorectal or uterine(endometrial) cancers on the same side of the family		

Office use only:
Meets criteria for genetic testing? Yes No
If yes, please check one:
_____Affected family member tested negative, testing not indicated.
_____Genetic test today.
_____Patient to consider (Brochure given: Yes No).
_____Referral sent for genetic counselling.
_____Other: _____

Provider signature: _____

Associates in Central Ohio Obstetrics and Gynecology, INC

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact the Privacy Officer at (614) 839-5555.
Effective date of the Notice: **April 28, 2015**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Source: U.S. Department of Health & Human Services

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Special Notes

Applicable State and Other Laws

Electronic Access

Associates in Central Ohio provides electronic access to your health information via Patient Privilege.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Source: U.S. Department of Health & Human Services