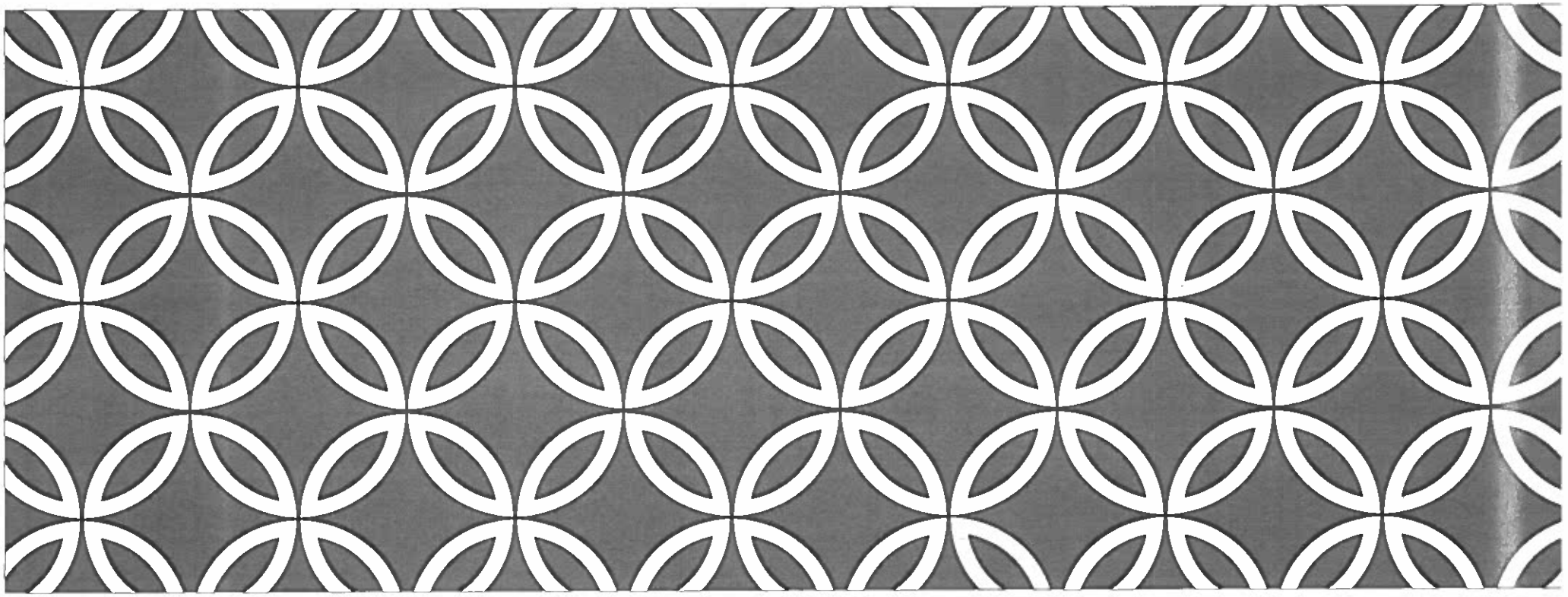

ASSOCIATES IN CENTRAL OHIO OBSTETRICS & GYNECOLOGY

575 Westar Crossing, Suite 102
Westerville, OH 43082
Phone: (614) 839-5555
Fax: (614) 839-5100

6482 East Main St, Suite B
Reynoldsburg, OH 43068
Phone: (614) 856-0327
Fax: (614)856-3300

NEW PREGNANCY PACKET

Appointment Date:
Arrival Time:
Physician:

IMPORTANT INFORMATION ABOUT OUR PRACTICE

OUR PRACTICE

Our practice consists of both male and female physicians. The physicians rotate taking call which means your care may be rendered by both. We also have multiple female nurse practitioners you might see for a visit when your physician is unavailable in the office. We have a male ultrasonographer who may scan you throughout your pregnancy. Our physicians deliver at the following hospitals ONLY: St. Ann's Hospital and Riverside Methodist Hospital

INITIAL OB OFFICE VISIT

Because of the physical exam, please do not douche or have intercourse 24 hours prior to your appointment. The visit will consist of an interview, physical examination, blood work and an ultrasound. The blood work at your initial visit will include determining your blood type, blood count, screening for prior vaccinations, and screening for viral infections including HIV, hepatitis B and hepatitis C as well as any other tests deemed medically necessary. Please allow 1.5 hours for your initial visit, even if you have been see at our practice previously for a pregnancy. All paperwork must be filled out completely. Bring insurance card. Arrive 30 min prior to your appointment time. We require 24 hour notice if you need to cancel or reschedule. Failure to do so will result in a no show charge of $52

INSURANCE

If your insurance carrier requires a referral from your primary care physician, it is your responsibility to obtain this referral prior to the date of your office visit. It is advisable for you to call our office prior to your visit to verify that we received your referral. If you do not have the proper referral by the time of your appointment, you will be asked to reschedule your appointment. Your insurance company will be contacted by the practice for verification of your maternity benefits. Our office DOES require payment of any deductible, copayments, or uninsured portions of services in full by your seventh month of pregnancy. Once this information is obtained from your insurance carrier, you will be set up on a monthly payment schedule for your payment responsibilities. We accept cash, check, or credit card (Visa, MasterCard, or Discover). For billing questions please call: 614-923-0153

INFORMATION REQUIRED PRIOR TO BEING SEEN

We require that you present your insurance card at every visit. If you had an insurance change and have not yet received your card from your insurance carrier, we ask that you contact our office prior to your appointment so that we may advise you of the information required to be seen. If you do not have insurance to cover your pregnancy, you are required to pay for your initial visit in full. A payment plan is possible for remaining costs of care and delivery.

HELPFUL TIPS FOR NAUSEA/VOMITING IN PREGNANCY

- Eat a piece of bread or a few crackers before you get out of bed in the morning or when you feel nauseated.

- Get out of bed slowly. Avoid sudden movements.

- Eat several small meals throughout the day.

- Eat high protein foods such as eggs, cheese, nuts, meat, as well as fruits. These foods help prevent low levels of sugar in your blood, which can contribute to nausea.

- Drink spearmint, peppermint, raspberry leaf, ginger root, ginger tea, or ginger ale.

- Take deep breaths. Get fresh air by taking a walk or opening a window.

- Try safe over the counter medications such as Vitamin B6 & Unisom. See details on "Safe Medications in Pregnancy" chart.

IMPORTANT INFORMATION ON GENETIC TESTING

- Screening tests can give information about a pregnant woman's risk of having a baby with certain birth defects or genetic conditions. These tests also can help your doctor detect possible problems during your pregnancy. Some pregnant women may have other tests, depending on their medical histories, previous pregnancies, family or ethnic background, or exam results.

- It is important to realize these are SCREENING tests, NOT DIAGNOSTIC tests. These tests ONLY provide information about whether your baby is at a higher or lower risk for certain conditions. A positive result DOES NOT necessarily mean your baby has the condition tested for. It will only direct us toward the need for additional, more definitive testing.

- **Trisomy 21**, or Down Syndrome, is a genetic condition that causes intellectual disability and other birth defects. On average this occurs in 1/700 births but risk increases with the age of the mother.

- **Trisomy 18**, or Edward's Syndrome, is a genetic condition that causes severe intellectual and physical disabilities . Most babies born with this condition will either die before birth or within the first year of life. It occurs in approximately 1/4,000 live births.

- **Trisomy 13**, or Patau Syndrome, causes severe intellectual and physical disabilities and most babies born with this will not live past the first week of life.

- **Neural tube defects** are birth defects that impact the brain and spinal cord. Most common defect is Spina Bifida which can cause issues with walking and bowel and bladder control. The risk of neural tube defects is 1/1,500.

- **Cystic Fibrosis (CF)** is one of the most common inherited diseases in the Caucasian population. It causes breathing problems and lung infections, as well as digestive problems and infertility. CF does not cause mental retardation or birth defects. People with CF might have a shortened life span, however many will live into their 40's or longer.

- **Spinal Muscular Atrophy** is a condition that affects the nervous system that controls voluntary muscle movement. It does not affect intelligence. It can be severe and significantly shorten a child's lifespan. Affects 1/9,000 people.

GENETIC TESTING OPTIONS

TEST	DESCRIPTION	TIMING	ADVANTAGES	DISADVANTAGES	MAX COST ESTIMATE
First Trimester Screen	- Assesses risk for Down Syndrome & Trisomy 13/18 - Blood test & ultrasound to measure fat pad on back of baby's neck	11-13 weeks	- Noninvasive - Detection rate of 95%	- 5% false positive rate	Bloodwork: $75-240 Ultrasound: $255 Total: $330-495
AFP	- Assesses risk for neural tube defects, such as spina bifida	15-19 weeks	- Noninvasive - Detects 80% of babies w neural tube defects	- Risk of false negative or false positive results	$99
AFP QUAD (If you did not have prior screening for Down Syndrome)	- Assesses risk for Down Syndrome - Assesses risk for neural tube defects, such as spina bifida	15-19 weeks	- Noninvasive - Does not require an ultrasound - Can be done in 2nd trimester	- Detection rate up to 81% - 6% false positive rate	$419

* These cost estimates are only approximate and are estimates through LabCorp. If your insurance requires you to have testing through a different lab, it is possible that costs may vary.

TEST	DESCRIPTION	TIMING	ADVANTAGES	DISADVANTAGES	MAX COST ESTIMATE
NIPT (Noninvasive prenatal testing)	- Blood test that looks for baby's chromosomes in your blood - Tests for Trisomy 21, 18, & 13 - Also reports gender - Only covered by insurance if >35 years old or have family history of chromosomal problems	After 10 weeks	- Noninvasive - Detection rate of 97-99%	- 5% false positive rate - May not be covered by insurance	$1,100
Cystic Fibrosis (CF) Carrier Screen	- Tests for 23 most common genetic mutations that cause C.F. - Most common autosomal recessive condition in Caucasian population - Screening recommended if patient or partner has personal or family history of C.F.	Anytime	- Noninvasive - Confirmatory diagnostics available - Can get specialists involved	- Risk of false negative result - May not be covered by insurance	$800
Spinal Muscular Atrophy (SMA) Carrier Screen	- Loss of nerve cells that control muscle movement - Can be very serious and cause early death - Recommended in patients with a family history	Anytime	- Noninvasive - Confirmatory diagnostics available - Can get specialists involved	- Risk of false negative result - May not be covered by insurance	$400-600

* These cost estimates are only approximate and are estimates through LabCorp. If your insurance requires you to have testing through a different lab, it is possible that costs may vary.

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

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

☐ 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

DELIVERING HOSPITAL: ST. ANN'S RIVERSIDE

Pre-Pregnancy Weight: _____

BREAST BOTTLE BOTH

Do you plan on attending childbirth classes? YES NO

Do you have cats in your home: YES NO

Have you had chicken pox? YES NO

Ok with transfusion if needed? YES NO

Father of Baby First Name: _____ **Phone Number:** _____ **Ok to call:** Y N

Father if Baby Ethnicity: _____

Menses:

Last Menstrual Period _____/_____/_____ **Menses Monthly:** YES NO

Frequency (days between periods):_____ **Last period:** definite unknown approximate (month known)

Normal Amount/Normal duration YES NO

Were you on Birth Control? YES NO

When did you have your positive home pregnancy test? _____/_____/_____

At what age did you start your periods? _____

REVIEW OF SYMPTOMS (Circle all that apply) **No associated symptoms**

Anorexia	Edema (Swelling)	Heartburn	Spotting
Bleeding	Fatigue	Irritability	Urinary difficulty
Breast Tenderness	Fever	Nausea	Vaginal Discharge
Constipation	Headache	Pelvic Pain	Vomiting

Additional Concerns_____

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: _____

Infection History

		Circle Yes Or No	
1	Do you live with someone or been exposed to TB?	Yes	NO
2	Do you have or have you been exposed to genital herpes?	Yes	NO
3	Have you had a rash or viral illness since last period?	Yes	NO
4	Do you have or have you been exposed to Hepatitis B or C?	Yes	NO
5	Do you have a history of the following:		
	Sexually Transmitted Disease?	Yes	NO
	Gonorrhea?	Yes	NO
	Chlamydia?	Yes	NO
	HPV/Genital Warts?	Yes	NO
	HIV?	Yes	NO
	Syphillis?	Yes	NO
6	Other?	Yes	NO

Genetic Screening/Teratology Counseling

		Circle Yes or No		Mother (patient)	Father (baby's)	Relative (mother or father)
1	Will you be 35 years or older when the baby is due?	Yes	No			
2	Have you ever been tested for Thalassemia? (Italian, Greek, Asian or Mediterranean background)?	Yes	No			
3	History of Neural tube defects? (Spina bifida, anencephaly or meningomyelocele)?	Yes	No			
4	Congenital Heart Defect?	Yes	No			
5	Down Syndrome?	Yes	No			
6	Tay-sachs (Ashkenazi Jewish, Cajun, French Canadian)?	Yes	No			
7	Canavan disease (Ashkenazi Jewish)?	Yes	No			
8	Familial dysautonomia (Ashkenazi Jewish)?	Yes	No			
9	Sickle cell disease or trait (Black/African)?	Yes	No			
10	Hemophilia or other blood disorders?	Yes	No			
11	Muscular dystrophy?	Yes	No			
12	Cystic Fibrosis (CF)?	Yes	No			
13	Huntington's chorea?	Yes	No			
14	Mental Retardation/Autism?	Yes	No			
15	Other inherited genetic or chromosomal disorder?	Yes	No			
16	Maternal metabolic disorder (Diabetes, PKU, etc.)?	Yes	No			
17	Do you or the baby's father have a child with birth defects not listed above?	Yes	No			
18	Have you had recurrent pregnancy loss or stillborn?	Yes	No			
19	Medications (including supplements, vitamins, herbs or OTC drugs/illicit or recreational drugs or alcohol since LMP?	Yes	No			
	_____					
	_____					
	_____					
20	Any other:	Yes	No			
	_____					
	_____					

Race: (Circle) White/Caucasian Black/African American Hispanic
Asian American Indian Other _____

OBSTETRICAL ULTRASOUND

I, _____, hereby request the performance of an **Obstetrical Ultrasound**. This procedure will be preformed by _____.

Ultrasound is a technique used to view the baby in the uterus (womb) with the use of sound waves. During an abdominal ultrasound examination, a gel is spread over your abdomen and a scanning device moves lightly over the area. As sound waves pass through the layers of the abdomen and uterus, they are reflected to show the developing baby, placenta, uterus, and nearby structures. These images are then converted into sound echoes, which can be seen on a monitor. In the case of vaginal ultrasound, performed in early pregnancy or in certain other situations, the scanning device is a small probe, which is placed inside the vagina. This is similar to having a pelvic examination and may be mildly uncomfortable.

This ultrasound test is not a treatment for any condition but is done for diagnostic purposes. The information obtained may be used to confirm the presence of fetal heart beat, evaluate the baby's growth, estimate the size of the baby, detect the presence of multiple fetuses, **and to detect some but not all birth defects**. It is possible that fetal birth detects may not be seen on the ultrasound examination performed today, or that anatomy could falsely appear abnormal. Therefore, neither a normal ultrasound nor the results of any prenatal test guarantee a normal, healthy baby.

Currently, there are no known health risks to the mother or fetus during an ultrasound examination.

There may be alternatives to this examination available to you. However, alternative methods of prenatal diagnosis have their own risks.

I acknowledge that I have had an opportunity to discuss with and have had explained to my satisfaction the purpose and nature of this obstetrical ultrasound, as well as reasonable risks. I understand that medicine is not an exact science, that it may involve the making of medical judgments based upon the facts known to the physician at the time, and that it is not reasonable to expect the physician to be able to anticipate or explain all possible risks and complications, and further, that an undesirable result does not necessarily indicate an error in judgment. I understand that no guarantee as to the results have been made to me. I expressly wish the physician to exercise his/her best judgment during the course of the procedure, and to inform me of the findings of the obstetrical ultrasound.

I DO or DO NOT wish to know the estimated gender of my baby. (Please circle one)

I understand that there is not 100% certainty when determining gender through ultrasound.

I understand that this obstetrical ultrasound may or may not be paid for by my insurance company. Many insurance companies will not pay for an ultrasound unless medical indications are present. I understand and agree that if the procedure is not paid for by my insurance, I will be responsible for the payment.

All my questions have been answered, and I do herby consent to the performance of an obstetrical ultrasound.

_____ _____

(Patient Signature) (Printed Patient Name)

_____ _____

(Physician/Provider Signature) (Date)

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

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 Obstetrics and Gynecology, INC

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

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