



Women's Health For Life, Inc.

1005 Bellefontaine Ave., Suite 175
Lima, OH 45804
(419) 227-2727
Fax (419) 227-2737
www.womenshealthforlife.com

770 West High Street, Suite 400
Lima, OH 45801

Thank you for selecting Women's Health for Life, Inc. to provide your OB/GYN care.

To make your first appointment run smoothly, please complete the enclosed information and bring it with you to your appointment. Any transferred records we receive from a previous physician are always kept confidential and will not be disclosed without your written permission.

HIPAA: If the patient is a minor, for any results to be released to the patient's parents, the patient must sign an authorization to release information form.

Our office hours are Monday thru Friday from 7:30-11AM and 12-4:30PM, except on Wednesday, when we have lunch from 12-1PM.

ALL prescriptions and authorizations for renewals must be requested during normal office hours. Normal test results will be mailed to you unless you have a return appointment. Any abnormal results will be called to you.

PATIENT RESPONSIBILITIES:

1. If you are unable to keep your appointment, you must notify this office at least 24 hours in advance.
2. If you are fifteen minutes late, your appointment WILL be rescheduled.
3. Please notify our office immediately of any changes in your insurance, address or phone number.
4. If we are providers for your insurance, you will be asked to pay your deductible or co-pay at the time of service. If you are self-pay you will need to pay for your visit in full.
5. We NOW ACCEPT CASH, CHECK, DEBIT AND CREDIT CARDS!
6. You are responsible to know how your insurance plan works.
7. You are responsible to tell the nursing staff if your insurance requires you to use a certain lab (ex: pap specimen, cultures, labs, etc.)

FEES NOT COVERED BY INSURANCE:

1. Third occurrence of not presenting for a scheduled appointment-\$28
2. Prescriptions rewritten - \$11
3. Disability, FMLA forms - \$6 per form
4. Non-sufficient funds returned check fee - \$33

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT:

1. The forms included with this letter
2. Photo of yourself (this photo will be returned)
3. Your insurance card
4. Any questions for the practitioner

We are glad you have chosen us to provide your care. The mission of our medical practice is to provide women with the best of care. We treat all patients with courtesy and respect and we expect our patients to return that courtesy to our personnel.



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PATIENT INFORMATION SHEET

Ms/Mrs. Circle One		First Name		MI	Last Name	
Address				City		State Zip
Home Telephone		Cell Phone		Date of Birth	Spouse's Name	
Social Security Number				Pharmacy & Address		
Referred By			Primary Care Physician	City	Phone	
Marital Status Single / Married		Does your insurance require a referral? Yes / No		Did you obtain the referral? Yes / No		
Emergency Contact & Relationship				Emergency Contact Phone Number (not home number)		
Employed By (Patient)				Work Telephone Number		Ext
Address of Employer				City		State Zip
Primary Insurance Plan				Social Security Number of Policy Holder		
Policy Number		Group Number		Expiration Date		
Name of Policy Holder		Date of Birth		Relation to Insured		
Address				City		State Zip
Telephone Number		Employer of Policy Holder			Employer Phone	
Secondary Insurance Plan				Social Security Number of Policy Holder		
Policy Number		Group Number		Expiration Date		
Name of Policy Holder		Date of Birth		Relation to Insured		
Address				City		State Zip
Telephone Number		Employer of Policy Holder			Employer Phone	
<p>PLEASE READ AND SIGN THE FOLLOWING: Thank You Authorization for Treatment: I authorize Women's Health for Life, Inc. and its staff to provide routine examinations, diagnostic tests, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain in effect until I withdraw it in writing.</p>						
Signature				Parent of Guardian Signature (if Minor)		
Date				Witness		



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GYNECOLOGY INFORMATION SHEET

Name				Age		Today's Date / /		
Why did you make this appointment?								
Family Physician			Marital Status M S D W			Insurance		
MEDICAL HISTORY				PREGNANCIES				
Have you ever had:		Yes	No	No.	Year	Months Pregnant	Type of Delivery	Problems
Heart disease				1.				
Lung disease				2.				
Kidney/Bladder disease				3.				
Seizure disorder				4.				
High blood pressure				5.				
Hyperlipidemia				Last Mammogram: / /			Normal?	Yes / No
Diabetes				Last Dexa Scan: / /			Normal?	Yes / No
Cancer				MENSTRUAL HISTORY				
Pelvic disease				Age periods started?			Regular? Yes / No	
Venereal disease				How often are your periods? Every			days.	
Tuberculosis				How long? days, from start to stop.				
Liver disease				Number of pads or tampons used each day?				
Blood disease				Pain with periods? Yes / No				
Mental illness				Spotting after intercourse? Yes / No				
Exposure to DES				Age of first sexual encounter?				
Drug dependency				Number of partners?				
Reaction to anesthetics				Are you using birth control? Yes / No				
Sexual abuse				Method?			Problems? Yes / No	
SURGICAL HISTORY				First day of last menstrual period?				
Year	Operation	City	Surgeon	Do you perform self breast exams?				
				PRESENT MEDICAL HISTORY				
				Do you feel you have problems with:		Yes	No	
				Ear, eyes, nose, throat, neck				
				Weight or appetite changes, infections				
MEDICATIONS (Name & Dosage)				Breathing or heart problems				
				Abdominal pain, bowel changes				
				Skin problems, joint or muscle aches				
				Memory loss or headaches				
ALLERGIES (reaction)				Menstrual periods/female organs				
				Breasts				
FAMILY HEALTH PROBLEMS (cancer, etc)				Energy/depression/weight/sleeping				
Father		Mother		Urinary symptoms				
Siblings				Abnormal bleeding				
Children				Hot flashes				
Grandparents				Hair growth				
How much do you smoke?				Pelvic pain with intercourse/sex life				
How much alcohol do you drink?				Marital problems				
Do you use IV or illegal drugs?				Date of last pap smear: / /		Normal? Yes / No		



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PATIENT NOTICE-OF-PRIVACY POLICY

What you need to know about the Confidentiality Policy

Women's Health For Life, Inc. is committed to providing you with high quality health care and to forming a relationship with you that is built on **trust**. That means respecting your **privacy** and **confidentiality** of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal medical information **only** for legitimate reasons.

Your medical record

As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan, and all treatment given, including the results of all tests, procedures, and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential

You, or anyone whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Women's Health For Life, Inc.

How do we assure your privacy?

Women's Health For Life, Inc. has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside Women's Health For Life, Inc. These policies conform with state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or the failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from her job.

We ask for your permission

We do not allow others outside Women's Health For Life, Inc. to access your medical information unless we have the appropriate authorization to do so. We will request your authorization to release information at your first visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

- Confidential details of:
 - Psychotherapy (from records of my treatment by a psychiatrist, licensed psychologist, or psychiatric clinical nurse specialist)
 - Other professional services of a licensed psychologist
 - Social Work Counseling/Therapy
 - Domestic Violence Victims' Counseling
 - Sexual Assault Counseling
- HIV test results (Patient authorization required for **EACH** release request.)
- Records pertaining to Sexually-Transmitted Diseases
- Alcohol and Drug Abuse Records

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of abuse of children or elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that it follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and

medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Women's Health For Life, Inc. without your written approval. In all research conducted within Women's Health For Life, Inc., concern for your privacy and well-being is our first priority.

If you have questions... If you have questions about the privacy of your medical records, please speak with your physician or the office manager, as appropriate. We will be happy to help you.

PLEASE READ AND SIGN THE FOLLOWING:

AUTHORIZATION FOR TREATMENT: I authorize Women's Health For Life, Inc. and its staff to provide routine examinations, diagnostic tests, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain in effect until I withdraw it in writing.

PATIENT NOTICE-OF-PRIVACY POLICY:

I have received and read the Patient Notice-Of-Privacy Policy and my signature acknowledges my understanding.

AUTHORIZATION AND ASSIGNMENT:

I authorize the release of any medical or other information necessary to process my medical claims. I also authorize and request that payment of benefits be made directly to Women's Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing.



Patient Signature (Parent or Guardian Signature if Minor)

Date

Witness

Date

IF MINOR-- MAY COMPLETE: I consent to releasing confidential health information to:

Recipient of Information

Patient Signature

Date



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FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash and check. We will be happy to process your claim for you. Any such request must be accompanied by a copy of all current insurance cards. If your yearly deductible has been met and you wish for our office to accept assignment, you will need to bring your most recent explanation of benefits from your insurance company showing that you have reached your deductible. **IT IS YOUR RESPONSIBILITY TO OBTAIN PREAUTHORIZATION FROM YOUR INSURANCE COMPANY WHEN REQUIRED TO PROCESS AND PAY YOUR CLAIMS.** Most insurance policies require that individuals first meet a deductible and that a specific amount be paid by an individual before reimbursement is allowed. Please contact your insurance company prior to your first visit.

For insurance plans in which Women's Health for Life, Inc. is a participating provider, we will still need a copy of your insurance card. You will only be responsible for applicable co-payments as specified by your insurance company.

Returned checks will be assessed an additional 33.00 charge. Balances over 30 days may be subject to additional collection fees and interest unless special arrangements are made with our accounting staff.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We do realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions or uncertainty about the above information, PLEASE don't hesitate to ask us. We are here to help you.

Sincerely,

Marilyn J. Kindig, D.O. and Staff

I have read and understand the above Financial Policy. I also understand that payment of all services rendered is ultimately my responsibility.

AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical or other information necessary to process my medical claim. I also authorize and request that payment of benefits be made directly to Women's Health for Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing.

Patient Signature (Guardian Signature if patient is under 18)

Date

Witness

Date



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AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____, do hereby request and grant my permission for release and/or exchange of all information relating to my care from and to the parties named:

FROM:

TO:

WOMEN'S HEALTH FOR LIFE, INC.
Marilyn J. Kindig, D.O.
1005 Bellefontaine Ave Suite 175
Lima, OH 45804
Telephone (419) 227-2727
Fax (419) 227-2737

This information may include but is not limited to the following:

- Medical Summary Sheet
- Obstetrics and Gynecology Operative Reports
- (Pap smears, mammograms, etc.) from the last five years
- Chicken pox immunity

To assist in identification and location of my records, I am providing the following information:

Name used when treatment occurred: _____

Social Security Number: _____ Date of Birth: _____

Signature of Patient or Legal Guardian

Date