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

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 inwriting.

Signature	Parent of Guardian Signature (if Minor)
Date	Witness

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OBSTETRICAL INFORMATION SHEET

Name	Age	Today's Date
		/ /

Date of Birth	Marital Status	Occupation
/ /		

Last Grade Completed	Family Practitioner	Insurance

Date of Last Menstrual Period	How often are periods & days long?	Was pregnancy planned?	Were you on birth control?
/ /		Yes / No	Yes / No

PAST PREGNANCIES

Date	Weeks	Length of Labor	Weight	Delivery Type	Where Delivered	Complications
/ /						
/ /						
/ /						
/ /						
/ /						

PAST MEDICAL HISTORY

	Yes	No		Yes	No
Sugar Diabetes			Infertility		
High Blood Pressure			Blood Transfusions		
Heart Problems			Mother Exposed to DES		
Heart Valve Problems			Rh Sensitization (Rhogam)		
Kidney Disease or Infections			Tuberculosis		
Neurologic/Seizures			Lung Problems – Asthma		
Depression/Mental Problems			Anesthetic Complications		
Hepatitis/Liver Disease			History of an Abnormal Pap		
Leg Vein Problems			Uterine Abnormality		
Thyroid Problems			Major Accident		

Have you, the baby's father or anyone in either family had:
Thalassemia, neural tube defects, downs syndrome, tay-sachs disease, sickle cell, hemophilia, muscular dystrophy, cystic fibrosis, huntington's chorea, mental retardation, inherited chromosomal defects, or babies born with birth defects? If so indicate whom.

Do you or your partner have genital herpes?

Have you had a rash or illness since your last menstrual period?

Have you ever had a sexually transmitted disease (gonorrhea, chlamydia, condyloma, trichomonas or syphilllis)?

Details of yes answers:

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OBSTETRICAL INFORMATION SHEET PAGE 2

SURGICAL HISTORY

Year	Operation	City	Surgeon	Complicaitons

Current Medications:

Allergies & Reactions:

Cigarette Smoking:

Alcohol Consumption:

Drug or Marijuana Usage:

FAMILY MEDICAL HISTORY

Father

Mother

Siblings

Children

Grandparents

Aunts/Uncles

Cousins

CURRENT MEDICAL HISTORY

Please circle if you have any of the following:
Weight changes, appetite changes, unusual weakness, bleeding, chills, fevers, recent accidents or infections. Vision changes, hearing changes, bloody noses, unusual sneezing, sore throat, swallowing difficulties, ear pain or face pain. Neck pain, swelling or stiffness. Cough, difficulty breathing or coughing up blood. Chest pain or chest fluttering. Abdominal pain, sickness to stomach, throwing up, diarrhea, constipation or problems with stools. Difficulty with urination. Joint stiffness, back pain, muscle cramps. Rash, skin lesions, easy bruising or itching. Memory loss, dizziness, double vision, clumsiness or headaches

Other issues to bring to the attention of our staff:

THANK YOU

Signature	Parent or Guardian Signature (if Minor)
Date	Witness

NUTRITION QUESTIONAIRE

Name ____

Date: _________ Height: _________ Weight Pre-pregnancy: _________ Today: __________ BMI: _________ Wt. Gain: _________

EATING BEHAVIOR

1) Are you frequently bothered by any of the following?
   (Circle all that apply)
   Nausea   Vomiting   Heartburn   Constipation
2) Do you skip meals at least three times a week? No Yes
3) Do you try to limit the amount or kind of food you eat to control your weight? No Yes
4) Are you on a special diet now? No Yes
5) Do you avoid any foods for health or religious reasons? No Yes

FOOD RESOURCES

6) Do you have a working stove? No Yes
7) Do you have a working refrigerator? No Yes
8) Do you sometimes run out of food before you are able to buy more? No Yes
9) Can you afford to eat the way you should? No Yes
10) Are you receiving any food assistance now? No Yes
    (Circle all that apply)

Food stamps	School breakfast	School lunch
WIC	Donated food/commodities	CSFP
Food pantry	Soup kitchen	Food bank

11) Do you feel you need help in obtaining food? No Yes

FOOD AND DRINK:

12) Which of these did you drink yesterday?
    (Circle and list servings of all that apply)

Soft Drink	Coffee	Tea	
Orange Juice	Grapefruit Juice	Fruit drink	
Milk	Kool-Aid	Water	
Beer	Wine	Alcoholic Drink	Other (List) __________________

13) Which of these foods did you eat yesterday?
    (Circle and list servings of each)

Cheese	Pizza	Macaroni and Cheese	
Yogurt	Cereal with Milk	Tacos with Cheese	
Enchilada	Lasagna	Cheeseburger	

Other (List) ____

Corn	Potatoes	Sweet Potatoes	Green Salad
Carrots	Collard Greens	Spinach	Turnip Greens
Broccoli	Green Beans	Green Peas	Other Vegetables ______________
Apples	Bananas	Berries	Grapefruit
Melon	Oranges	Peaches	Other Fruit ___________________
Meat	Fish	Chicken	Eggs
Nuts	Seeds	Peanut Butter	Dried Beans
Cold Cuts	Hot Dog	Bacon	Sausage
Cake	Cookies	Doughnut	Pastry
Chips	French Fries	Other Fried Foods ____________________________________	
Bread	Rolls	Rice	Cereal
Noodles	Spaghetti	Tortillas	

Were any of these whole grain? No Yes

14) Is the way you ate yesterday the way you usually eat? No Yes
15) Do you exercise for at least 20 minutes three times a week? No Yes
    What type of exercise do you enjoy? ____

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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 Have you ever had:	Yes	No
Heart disease		
Lung disease		
Kidney/Bladder disease		
Seizure disorder		
High blood pressure		
Hyperlipidemia		
Diabetes		
Cancer		
Pelvic disease		
Venereal disease		
Tuberculosis		
Liver disease		
Blood disease		
Mental illness		
Exposure to DES		
Drug dependency		
Reaction to anesthetics		
Sexual abuse		

PREGNANCIES

No.	Year	Months Pregnant	Type of Delivery	Problems
1.				
2.				
3.				
4.				
5.				

Last Mammogram: / / Normal? Yes / No
Last Dexa Scan: / / Normal? Yes / No

MENSTRUAL HISTORY

Age periods started? Regular? Yes / No
How often are your periods? Every days.
How long? days, from start to stop.
Number of pads or tampons used each day?
Pain with periods? Yes / No
Spotting after intercourse? Yes / No
Age of first sexual encounter?
Number of partners?
Are you using birth control? Yes / No
Method? Problems? Yes / No
First day of last menstrual period?
Do you perform self breast exams?

SURGICAL HISTORY

Year	Operation	City	Surgeon

MEDICATIONS (Name & Dosage)

ALLERGIES (reaction)

FAMILY HEALTH PROBLEMS (cancer, etc)

Father Mother
Siblings
Children
Grandparents
How much do you smoke?
How much alcohol do you drink?
Do you use IV or illegal drugs?

PRESENT MEDICAL HISTORY

Do you feel you have problems with:	Yes	No
Ear, eyes, nose, throat, neck		
Weight or appetite changes, infections		
Breathing or heart problems		
Abdominal pain, bowel changes		
Skin problems, joint or muscle aches		
Memory loss or headaches		
Menstrual periods/female organs		
Breasts		
Energy/depression/weight/sleeping		
Urinary symptoms		
Abnormal bleeding		
Hot flashes		
Hair growth		
Pelvic pain with intercourse/sex life		
Marital problems		

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 fist 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 it's 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.

Retuned 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