Andrew Croak, DO ~ Tracey Begley, WHNP
Deanna Zaciek, NP-C ~ Nancy Pahl, WHNP-BC

Dear _____,

You have an appointment scheduled with our office on:

_____ at _____.

Welcome to our office. We are glad you chose us for all your personal care needs. ***We are located at a brand new location – 28442 E. River Road, #111 – in Perrysburg, Ohio.*** *We can be reached at* ***419 893 7134*** *if you have questions*.

It is mandatory that you bring your insurance card, driver's license, and any co-pay at the time of your visit.

Please fax or mail all completed paperwork prior to your visit. ***FAX: 419 893 6942***

We look forward to meeting you, and being able to assist with all of your needs and concerns.

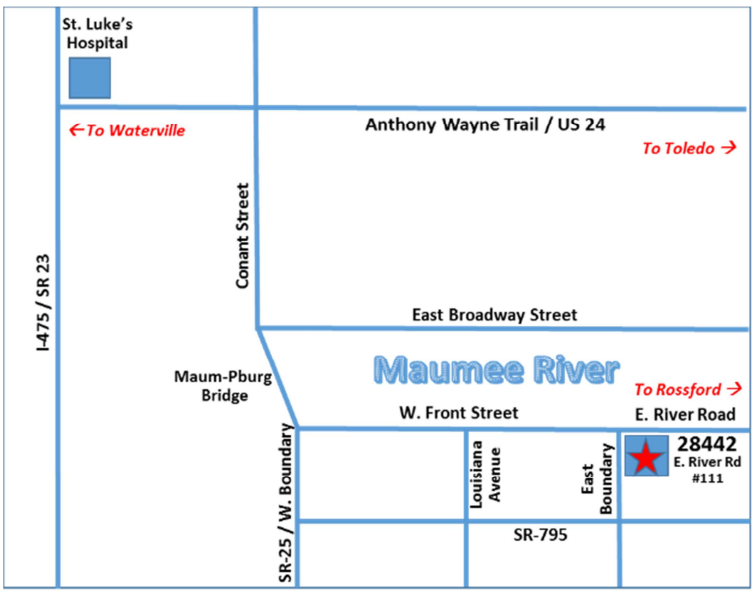
Directions to the Office:

From I-475: Exit expressway at SR-25 Perrysburg exit. Go north on SR-25 (W. Boundary) and follow to intersection of Maumee-Perrysburg Bridge & W. Front Street. Turn right on W. Front Street and follow to East Boundary. Building is on your right.

From Downtown Toledo: Take on ramp for I-75 South. Exit at the Rossford SR-65 West (Hollywood Casino) off ramp. Follow SR-65 through Rossford into Perrysburg (name changes to E. River Road. Building will be on your left.

From Reynolds Road, West Toledo: Take Reynolds Road (US-20) that passes under the Ohio Turnpike Exit 4A, into Maumee (Conant Street) all the way to Maumee Perrysburg Bridge. Cross bridge (stay in left lane) and follow into Perrysburg (becomes W. Front Street) to East Boundary. Building is on your right.

From Ohio Turnpike: Exit Perrysburg SR-795 Exit. Follow SR-795 east to East Boundary. Turn left on East Boundary, cross railroad tracks, and you will see the building on your right. Parking lot accessible from East Boundary Street.



Practice	Patient Num	*** PATIENT REGISTRATION FORM *** *Read Thoroughly, Complete all Blanks & Please Print Neatly*	New / Update

PATIENT NAME _____ _____
LAST NAME *FIRST NAME, MI.*

Address _____ CITY _____ ST._____ ZIP_____

Phone *[Home]* (____) _____-_____ *[Other]* (____) _____-_____ Marital Status ... ***Single*** / ***Married*** / ***Other***

Social Security No. ___-___-_____ Date of Birth ____/____/____ Age _____ Sex ... ***Male*** / ***Female***

Employment Status... ***Employed*** / ***FT Student*** / ***PT Student*** / ***None*** ... **at** _____

Co-Pay *(If Any)* **$** _____ Email _____ Ref. Physician _____

Diagnosis _____ Allergies to _____

Responsible Party _____ Phone (____) _____-_____

Emergency Contact _____ Phone (____) _____-_____

PRIMARY INSURANCE CARRIER

Ins. # _____ Insurance Co. Name _____
NCDS - Only

ID No. _____ Grp. No. _____ Emp. _____

Insured Name _____ _____ Pt. Relation ***Self*** / ***Spouse*** / ***Child*** / ***Other***
LAST NAME *FIRST NAME, MI.*

Address _____ Date of Birth ____/____/____ Sex ..... ***Male*** / ***Female***

City _____ St. ____ Zip _____ Phone (____) _____-_____

**** billed at the practice's discretion only ****

SECONDARY INSURANCE CARRIER

**** not billed for an office visit copay balance ****

Ins. # _____ Insurance Co. Name _____
NCDS - Only

ID No. _____ Grp. No. _____ Emp. _____

Insured Name _____ _____ Pt. Relation ***Self*** / ***Spouse*** / ***Child*** / ***Other***
LAST NAME *FIRST NAME, MI.*

Address _____ Date of Birth ____/____/____ Sex ..... ***Male*** / ***Female***

City _____ St. ____ Zip _____ Phone (____) _____-_____

**** If a Medicare Plan is Secondary Payor Please Give Reason Here** _____ **** REQUIRED ****

Consent for Treatment I as the patient or legal guardian of, authorize the **Insurance Carrier** to make checks for medical expenses due me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the **Insurance Carrier**. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.

*** Payment Terms Noted ***

- **This practice accepts the UCR fee of participating carriers. In the event of two carriers the higher of the UCR fees will be considered.**
- **Delinquent accounts may be referred for third party collection and may be charged for associated collection and attorney/legal fees.**

PLEASE PRESENT INSURANCE CARD WITH THIS FORM

X _____ ____/____/____
Signature *Date*

To update the above information, view your account and make payments online.
Visit www.ncdsinc.com and click on "Patient Login"

Northwest Ohio
Center for Urogynecology and Women's Health

Patient Name: _____ DOB: _____

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

Oral communication via telephone:

☐ Home: _____ ☐ Cell: _____ ☐ Work: _____

☐ OK to leave message with detailed information: ☐ Home ☐ Cell ☐ Work

☐ Leave message with call-back number only: ☐ Home ☐ Cell ☐ Work

☐ Other: _____

Written communication:

☐ OK to mail to my home address ☐ OK to fax to: _____

☐ OK to mail to my work/office address: _____

☐ Other: _____

☐ I permit the Practice to discuss my personal health information (PHI) with, and to disclose to, the following individuals: (If you check a box, please list a **NAME & CONTACT NUMBER** next to it)

- ☐ Spouse _____
- ☐ Adult Child (ren) _____
- ☐ My parent (s) _____
- ☐ Personal representative _____

☐ If checked, the following additional instructions apply: _____

_____

SIGNATURE THAT PATIENT HAS RECEIVED PRIVACY FINANCIAL POLICY PAMPHLET:

_____ _____

Patient Signature Date

If signed by patient's authorized representative, describe the representative's authority.

□ Patient is a minor; I am the patient's parent and natural guardian
□ Patient is a minor, I am the patient's guardian, appointed by the _____ County Juvenile Court.
□ Patient is a ward; I am the patient's guardian, appointed by the _____ County Probate Court.
□ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
□ Other (describe) _____

STAFF INITIALS: _____ ***DATE:*** _____

Northwest Ohio
Center for Urogynecology and Women's Health

Name _____ Age _____ Date of Birth _____ Today's Date

Who referred you to our office? _____Primary Care Provider _____

What is the reason for your visit today? _____

Menstrual History

Age at first menstrual period _____ First day of your last period _____ If applicable: How many days do your periods last? _____
How many pads/tampons do you typically use in a 24 hours? _____ pads _____ tampons

	Yes	No	N/A
Are your menstrual cycles regular (every 21-35 days)?			
Do you have bleeding or spotting between periods?			
Do you have pain with your periods?			
Do you have pain in your lower abdomen or pelvis other than painful periods?			
If you are menopausal, have you experienced any further vaginal bleeding?			

Sexual History

	Yes	No	N/A
Are you sexually active? (If yes, please circle: with a man/woman/both)			
Do you have pain with intercourse?			
Do you have bleeding during or after intercourse?			
Are you satisfied with your current sexual health?			
Are you using birth control? If yes, what method? _____			
Have you ever had a sexually transmitted infection? If yes, please explain _____			

Pregnancy History

Total number of pregnancies: _____ Number of deliveries:_____ Miscarriages:____ Abortions:____ Ectopic pregnancies:_____

Have you recently had any of the following symptoms (within the last month)?

	Yes	No		Yes	No		Yes	No
Vaginal discharge			Burning or pain with urination			Pressure or bulge at the opening of the vagina		
Vulvar itching or irritation			Leakage of urine					
Breast pain			Frequent urination			Incontinence of stool		
Breast lump/mass			Difficulty emptying your bladder			Blood in your stool		
Hot flashes and/or night sweats			Urinary tract infections			Significant/chronic diarrhea		
Weight gain/loss of 10 lbs			Chronic coughing			Significant/chronic constipation		

Personal Medical History (check all that apply)

O Breast cancer	O Tension headaches	O Thyroid disease	O Jaundice/Hepatitis
O Ovarian cancer	O Migraine headaches	O Parkinson's disease	O HIV/AIDS
O Uterine cancer	O Seizures/Epilepsy	O Osteoporosis/osteopenia	O Birth defects
O Colon cancer	O Multiple sclerosis	O Bone fracture	O Exposure to DES
O Other cancer: _____	O Anxiety	O Vitamin D deficiency	O Digestive problems
O Abnormal pap test	O Depression	O Arthritis	O Breast problems
O Diabetes	O Heart attack	O Joint replacement	O Colon problems
O High blood pressure	O Stroke	O Lung disease _____	O Bladder/kidney disease
O High cholesterol	O Blood clots: _____	O Skin problems _____	O Urinary infections
O Heart disease	O Heart valve problem	O Anemia	O Glaucoma

Please provide details for any conditions selected above or list other diagnoses not above: _____

_____

_____

Do you have to take antibiotics before dental work or other procedures? O Yes O No If yes, _____

(Reason)

Drug/Food/Other Allergies (Please include reaction, i.e. hives): _____

Surgical History

Date	Procedure	Reason for Surgery

Medications

Please list all prescription and over-the-counter medications, vitamins, and herbal supplements:

Name of medication	Dose	How often taken	**Name of medication**	Dose	How often taken

Your Local Pharmacy:
Name _____ Address _____ Phone # _____

Mail order pharmacy:
Name_____ Phone # _____

Family History

Please include relationship and age at diagnosis:

Diagnosis	Relationship	Age at Diagnosis	Diagnosis	Relationship	Age at Diagnosis
Breast cancer			Heart disease		
Uterine cancer			Stroke		
Ovarian cancer			Heart attack		
Colon cancer			High cholesterol		
Other: _____			Genetic disease		
Osteoporosis			Anesthesia complication		
Diabetes			Clotting disorder		
Hypertension			Other:		

Social History

Marital Status: O Single O Married O Divorced O Widowed Occupation: _____ O Retired

How many servings of caffeine do you consume per day? _____ Type? _____

Do you currently smoke? O Yes O No # Cigarettes/Day: _____ How many years? _____

If no, did you ever smoke? O Yes O No How long ago did you quit? _____

Do you consume alcohol? O Yes O No How many alcoholic beverages/week? _____ Do you use illicit drugs? O Yes O No

In an average week, how many minutes of vigorous physical activity do you get? _____

Do you consume foods/drinks containing calcium on a daily basis? (i.e., milk, yogurt, cheese, etc.) O Yes O No

Please list any religious or cultural needs regarding your care: _____

Preventative History

Last Pap Smear/Pelvic Exam: _____ Facility: _____

Have you ever had an abnormal pap smear? O Yes O No Treatment if applicable: _____

Last Mammogram: _____ Facility:_____

Have you ever had an abnormal mammogram? O Yes O No Treatment if applicable: _____

Last Bone Density Test (DEXA scan): _____ Facility: _____

Last Colonoscopy/sigmoidoscopy: _____ Facility: _____

Are you up-to-date on your immunizations? O Yes O No

Dates of Last: Flu: _____ Tdap: _____ Pneumonia: _____ Herpes Zoster (Shingles): _____ Gardasil (HPV): _____

Have you ever had any prior physical, occupational, speech or chiropractic treatments this year?

O Yes O No If yes, how many? _____

OFFICE POLICIES SIGNATURE PAGE

Date Packet Issued: _____ **Issued by:** _____ **(initials)**

Thank you for choosing the Northwest Ohio Center for Urogynecology and Women's Health as your health care provider. We are committed to your treatment being successful. Listed below are pertinent points taken from our Office Policies Packet. ***Please read the ENTIRE Office Policy Packet for complete clarification***. This form is a highlighted version that requires signature. A copy will be returned to you.

HIPPA PRIVACY STANDARDS: The United States Department of Health and Human Services has adopted privacy standards -- the "HIPAA Privacy Standards"-- which protect your health information. The HIPAA Privacy Standards establish rules for when healthcare providers and billing agents, such as NCDS Medical Billing, may use or disclose your health information. Importantly, the HIPAA Privacy Standards also tell us what we cannot do with your health information. Activities that are not permitted under HIPAA will require your written authorization. This requires updating and signature yearly. Please refer to the complete packet for clarification.

BILLING & INSURANCE:

• CREDIT CARD ON FILE: With changes in healthcare, we are requesting credit card information be maintained by this office. This information would remain STRICTLY CONFIDENTIAL and only be used per patient request or if an outstanding balance remains after insurance clears. Patients would be notified regarding any amount above $300.00.

• No Insurance: ***If you do not have insurance, payment in full is expected at the time of service.***

• Co-Pays: ***All insurance co-pays are due at the time of service as required by your insurance company***. If you carry a secondary insurance, a co-pay is still required based on insurance guidelines. ***If you do not have your copay but still wish to be seen, a $30 fee will be applied to your account.***

• Pre-surgical Payments: A deposit may be required to schedule elective surgery and is determined by your insurance deductible owed or by cash fee for service. Any deposit is due 2 weeks prior to the scheduled surgery date.

• Plan Participation: ***It is the patient's responsibility to know and understand their insurance plan.***

• Secondary Insurers: A patient is responsible for any balances after your primary insurance has cleared. Secondary insurance may be billed as a courtesy, with no guarantee of payment.

• Referrals: If you belong to an insurance plan that requires a referral for specialist care, it is your responsibility to obtain the referral from your Primary Care Physician (PCP) prior to your visit with us.

• Patient Statements: If there is a balance on account, you will receive a monthly statement showing amount due. An unpaid balance is considered past due after 45 days. If two consecutive statements have been sent to you but no payment has been received on your account to reduce your responsibility, you may receive a collection letter and be considered for further collection activity.

PENDING OR THREATENING LITIGATION: Dr. Croak takes care of many patients who have had suboptimal surgical outcomes elsewhere. Some situations may not be able to be helped to a patient's degree of satisfaction despite Dr. Croak's best efforts. Because of this fact, Dr. Croak makes it clear that if you are threatening or involved in pursuing litigation for a prior suboptimal outcome, it is your responsibility to inform him of your plan at the time of your first consultation. Dr. Croak reserves the right to decline care at any time pending investigation into your specific situation. The failure to disclose litigation will result in immediate termination from the practice.

MISSED/CANCELLED APPOINTMENTS: If you do not show for an appointment or do not cancel a scheduled appointment 48 hours in advance, a $50 fee may be charged to your account. Repeated missed or cancelled appointments may result in termination of services with this office. If you run late for your appointment (10 minutes or more), staff reserve the right to reschedule the appointment.

THESE POLICES REMAIN IN FORCE INDEFINITELY AND/OR IF ANY REVISIONS ARE MADE TO SAME.

I have received, read and understand the Office Policies of the NWO Center for Urogynecology & Women's Health & NWO Center for Pelvic Rehabilitation & Wellness.

_____ Date:_____

Patient Signature

_____

Printed Name

Rev 03/31/2015

CREDIT CARD ON FILE POLICY

The Northwest Ohio Center for Urogynecology & Women's Health and the Center for Pelvic Rehabilitation & Wellness will be asking you to put a credit card on file (CCOF) effective 4/1/15.

DESCRIPTION: Similar to paying a deposit for a hotel room, having a credit card on file will allow for deposit payment related to visits, procedures, surgery, therapy, and unpaid balances. Patients find this policy respectfully addresses financial responsibility by giving them the courtesy of knowing what charges may be ahead of time. We respect those who may not have a credit card or desire a CCOF, and have developed the policy below to reflect everyone's situation.

PROCEDURE:

1. Copays are due at the time of service, per office policy.

2. A CCOF will be secured under locked storage (per industry standards) and will not be stored in the patient's record or computer.

3. Deposits for **high deductible office visits or in-office procedures** will be reviewed and patients notified of their responsibility in advance. Procedures may require deposits of greater than $300.

4. **Surgical deposits** will be reviewed based on deductible of insurance policy. This deposit may be greater than $300 due to type of surgery planned. Patients will be notified regarding this amount.

5. For balances post due 60 days, an automatic maximal charge of up to $300 will be rendered. Balances greater than $300 will require patient notification and discussion, with our billing company for payment. We also offer other options for payment such as a payment plan or Care Credit.

6. Patients may authorize payment for services related to remaining balances at any time utilizing the CCOF.

7. Patient in default past 90 days could have their account sent to a collection agency.

We appreciate your cooperation with this policy. Patient care has always been, and will always be our #1 priority. It is understood that discussions about healthcare and payment for health services may be emotional and difficult. It is not our intent to cause financial hardship, but to be reimbursed in a timely manner for services rendered.

We know patients value coming to our independent practice because of individualized, specialized care that is sincere in its personal touch. Please assist us in this continual process by reviewing and agreeing to this policy.

SIGN ONE BELOW

I, _____ understand and agree to this policy of having credit card information including 3-digit code) on file with NWO Center for Urogynecology & Women's Health and NWO Center for Pelvic rehabilitation & Wellness to be utilized for payments for services rendered or to be rendered as outlined above.

I,_____ understand by **DECLINING** this CCOF policy, any balance owed at the time of visit must be paid in full or the visit will need to be rescheduled after the balance is paid.

Patient Name: _____ Date: _____
(Printed)

Signature: _____ Date: _____

Witness: _____ Date: _____

CREDIT CARD INFORMATION SHEET

PATIENT NAME: _____ NCDS # _____

ADDRESS: _____ DOB: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ DEBIT CARD

CARD #: _____ CVC 3-DIGIT: _____ EXPIRATION: _____

☐ CHECK HERE IF CARDHOLDER INFORMATION SAME AS PATIENT INFORMATION

CARDHOLDER NAME: _____

CARDHOLDER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____

This credit card information will be secured under locked storage and only accessible by the Office Manager or Provider. By giving this information, you authorize NWO CENTER FOR UROGYNECOLOGY & WOMEN'S HEALTH and NWO CENTER FOR PELVIC REHABILITATION & WELLNESS to use your card in circumstances of deposits towards high-deductible plans or unpaid balances on account after insurance pays or makes adjustments, not to exceed $300.00. Additional processing may occur per patient request for deposits towards testing or surgery. This form will be updated as notified by the patient that information has changed.

Patient Name: _____ Date: _____
(Printed)

Signature: _____ Date: _____

FOR CONFIDENTIALITY REASONS,

PLEASE DO NOT FAX OR MAIL THIS SHEET.

PLEASE BRING WITH YOU TO YOUR SCHEDULED APPOINTMENT.

Northwest Ohio
Center for Urogynecology and Women's Health

PATIENT NAME: _____ **BIRTHDATE:** _____

PLEASE COMPLETE THE FOLLOWING:

RACE:	**PLEASE CIRCLE ONE:** American Indian Asian Black or African American DECLINED Native American Not Reported Unknown White
ETHNICITY:	**PLEASE CIRCLE ONE:** Hispanic or Latino Non-Hispanic or Latino DECLINED
LANGUAGE:	
PCP:	

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT PORTAL REGISTRATION

The FollowMyHealth™ patient portal at the NWO CENTER FOR UROGYNECOLOGY is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize NWO CENTER FOR UROGYNECOLOGY to email an invitation to create a portal account.

PERSONAL ACCOUNT ACCESS: *(photo ID required)*

Patient Information *(please print)***:**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize* NWO CENTER FOR UROGYNECOLOGY *to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to* NWO CENTER FOR UROGYNECOLOGY *health care information:

Patient Signature: _____ Date: _____

PROXY ACCOUNT ACCESS: *(copies of legal documents and photo ID required)*

☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*

☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*

☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**

☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Proxy Information *(please print)***:** (Person receiving access to a Patient Portal account)

Proxy Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Proxy DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where **PROXY** portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Proxy Signature: _____ Date: _____

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: Date:

For Portal Use Only

Patient Portal Invite sent by: Date:

(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)