Costas A. Apostolis, MD
Summit Urogynecology
3009 Smith Road, Ste 400, Fairlawn, OH 44333
7641 Market St, Ste 2, Youngstown, OH 44512
Phone: (330) 953 3414 / Fax: (877)753-3179

Name: _____

Patient Registration Instructions: **Please complete the following information and bring with you to your first appointment.**

Patient Name: _____ _____ _____
Last First M.I.

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

D.O.B: _____ Social Security Number: _____ - _____ - _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____

Employer: _____ Work Phone: ( ) _____

Work Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE

Insured Name: _____ D.O.B: _____

Member ID:_____ Group Number: _____

Insurance Name:_____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Provider Phone: ( ) _____

SECONDARY INSURANCE

Insured Name: _____ D.O.B: _____

Member ID:_____ Group Number: _____

Insurance Name:_____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Provider Phone: ( ) _____

Emergency Contact: _____ Phone: ( ) _____

Relationship: _____

Pharmacy Name: _____ Phone: ( ) _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

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Name: _____

We would like to send a letter or copy of your office visit to your referring physician and your primary care physician. Please indicate which doctors you would like this information sent to by checking the appropriate boxes. In order for the report(s) to be sent out in a timely manner, we would appreciate your supplying us with the following information:

□ Gynecologist

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____

□ Primary Care Physician

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____

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Name: _____

PATIENT HISTORY

Please Print:

Who referred you to see us? _____

What is the reason for your visit today? _____

Pregnancy history

Number of pregnancies: _____
Number of living children: _____
Weight of largest baby: _____
Number of vaginal deliveries: _____
Forceps delivery? □ Yes □ No
Number of c-sections: _____

Medical History (check all that apply)

□ Heart disease
□ Diabetes
□ Asthma
□ Stroke
□ Anxiety
□ Glaucoma
□ Blood clots in legs
□ High blood pressure
□ Depression
□ Psychiatric disorder

Surgical History

□ Bladder surgery
□ Prolapse surgery
□ Hernia surgery
□ Hysterectomy: abdominal or vaginal?
□ Ovaries removed?

Other medical problems:

_____
_____
_____
_____

Other surgeries:

_____
_____
_____
_____

Medications: □ None

_____ Dose/Freq: _____
_____ Dose/Freq: _____
_____ Dose/Freq: _____
_____ Dose/Freq: _____

Drug Allergies: □ None **Reactions:**

_____ _____
_____ _____
_____ _____
_____ _____

Social History □ Single □ Married □ Partner □ Separated □ Divorced □ Widow

Do you work?	Y	N	What do you do? _____
Exercise?	Y	N	How often? _____
Sexually Active?	Y	N	How often? _____
Do you smoke?	Y	N	How many packs per day? _____
Alcohol?	Y	N	Type of alcohol: _____ How often? _____
Caffeine?	Y	N	Type: _____ How often? _____
Recreational drugs?	Y	N	Type: _____ How often? _____

Do you feel safe in your relationship? _____

Family History: *Have any of your close family members (parents, children, siblings) had the following?*

	Relationship		Relationship
High cholesterol	_____	Prolapse surgery	_____
Heart disease	_____	Diabetes	_____
High blood pressure	_____	GYN cancer	_____
Bladder surgery	_____	Other cancer	_____

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Name: _____

PATIENT HISTORY (continued)

Review of Systems: *Do you have any of these problems now?*

General
□ Feeling tired
□ Fever
□ Significant weight loss/gain

Breast
□ Breast lumps
□ Breast tenderness
□ Nipple discharge

Ears/nose/mouth
□ Hearing loss
□ Ear pain
□ Sore throat
□ Snoring
□ Dry mouth
□ Mouth ulcers

Lungs
□ Shortness of breath
□ Cough frequently
□ Cough up mucus or blood
□ Wheezing

Musculoskeletal
□ Muscle aches
□ Muscle weakness
□ Joint pain
□ Back pain

Neurologic
□ Frequent headaches
□ Dizziness
□ Pass out
□ Weakness
□ Numbness

Endocrine
□ Hot flashes
□ Night sweats
□ Vaginal dryness
□ Decreased sex drive
□ Problems having orgasm

Gastrointestinal
□ Heartburn
□ Pain with swallowing
□ Nausea or vomiting
□ Abdominal pain
□ Diarrhea
□ Constipation
□ Rectal bleeding

Eyes
□ Irritation
□ Vision changes

Skin
□ Abnormal mole
□ Rash

Heart
□ Chest pain
□ Palpitations
□ Shortness of breath when lying down

Psychiatric
□ Depression
□ Alcoholism
□ Insomnia

Genitourinary system

Do you urinate frequently? □ Yes □ No

Do you have to rush to get to the bathroom? □ Yes □ No □ Sometimes

Do you have pain or burning when you urinate? □ Yes □ No □ Sometimes

Is your urine ever bloody? □ Yes □ No □ Sometimes

Do you accidentally lose urine with any of the following activities?

□ laughing □ sneezing □ exercising □ getting out of bed
□ coughing □ lifting □ standing up

Do you lose urine during sex? □ Yes □ No □ N/A

Do you ever get up from sleeping to go to the bathroom? □ Yes (How many times? _____) □ No

Do you ever lose urine while sleeping? □ Yes □ No

Do you ever leak urine after a strong urge? □ Yes □ No □ Sometimes

Do you wear pads for your leakage? □ Yes □ No

If yes, what type? □ Pantyliner or tissue □ Pad (How many per day? _____) □ Adult diaper

Do you dribble after going to the bathroom? □ Yes □ No □ Sometimes

Do you ever have trouble emptying your bladder? □ Yes □ No □ Sometimes

Do you ever push to empty your bladder completely? □ Yes □ No □ Sometimes

Is your urine stream: □ Continuous □ Start and stop

Is your urine stream: □ Strong □ Weak □ Variable

Do you feel your pelvic organs are falling out? □ Yes □ No □ Sometimes

Do you feel anything bulging out of the vagina? □ Yes □ No □ Sometimes

Do you feel heaviness or pressure in the vagina? □ Yes □ No □ Sometimes

Are your bowel movements: □ Normal □ Constipated □ Diarrhea □ Variable

Do you ever leak or lose stool? □ Never □ Rarely □ Monthly □ Daily

SUMMIT UROGYNECOLOGY NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review this notice carefully.**

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 will 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 have 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 will 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 at the end of this notice.
  - 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 by 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
- In the case of fundraising:
  - We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

- 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 are complying with federal privacy law.
- Respond to organ and tissue donation requests
  - We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
  - 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.

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

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

This Notice describes how Summit Urogynecology may use and disclose your protected health information. The terms of this Notice of Privacy Practices are effective August 14th, 2017. 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.

Contact Information:

If you have any questions about this Notice, or have a complaint, then please contact the following Privacy Officer:
Konstantina Apostolis
3009 Smith Rd, Ste 400
Fairlawn, OH 44333
P: 234.303.2730

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

The Clinic is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Print name

_____
Date

****

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:
□ The patient refused to sign.
□ Due to an emergency situation it was not possible to obtain an acknowledgement.
□ We weren't able to communicate with the patient.
□ Other (Please provide specific details)

Employee Signature: _____

Date: _____

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PATIENT FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your relationship as our patient. We file insurance claims as a courtesy to our patients. The guidelines below help you assist us with this process.

- Each patient must bring their insurance information (primary, secondary, tertiary) and a photo ID to every appointment to ensure correct processing of all insurance claims. Failure to provide complete insurance information may result in patient responsibility for the entire bill.
- It is every patient's responsibility to understand their insurance policy and benefits.
- Payment is due at the time of services, including copayments, deductibles, and coinsurance.
- There is a $35.00 fee for all returned checks.
- If you do not show up for an appointment or cancel with less than 24 hours notice, you will be charged $50.00. You must pay this fee before you can schedule a new appointment. Patients with three missed appointments may be terminated from the practice.
- If your insurance company is not contracted with us and/or denies payment because of benefit limitations or non-covered services, you will be responsible for the charges.
- Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and **the balance will be your responsibility**.
- If your insurance company needs any additional information, you are responsible for providing it to them.
- I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must provide my current address and other contact information.
- It is our office policy that all past due accounts be sent three statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.
- In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

PATIENT OR RESPONSIBLE PARTY

I hereby assign the benefits from my insurance or any third party to Olympic Urogynecology, LLC dba Summit Urogynecology and/or Costas A. Apostolis, MD for medical services provided to me. I authorize Olympic Urogynecology, LLC dba Summit Urogynecology to release any information necessary to determine benefits and to process a claim filed on my behalf to Medicare or any third-party insurance disclosed.

I have read, understand, and have been allowed to ask questions about this policy. I agree to comply with the guidelines above as described.

Signature: _____

Printed Name: _____ Date: _____

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Authorization for Release of Health Information Pursuant to HIPAA

Section A: This section must be completed for all Authorizations.

Patient Last Name:	First Name:	MI:
Date of Birth:	Social Security Number (optional):	
My health information may be released **from** (name of sender):		
Address:		
City, State, Zip:		
My health information may be released **to** (name of recipient): **Summit Urogynecology**		
Address: 3009 Smith Rd, Ste 400		
City: Fairlawn	State: OH	Zip: 44333

I hereby authorize the use or disclosure of protected health information as described below:

Description of information being disclosed for the following date(s) of service:

❒Complete health record	❒Abstract/Pertinent Information	❒Consultation Reports
❒History/physical exam	❒HIV/AIDS Information	❒Laboratory Reports
❒Progress Notes	❒Drug/Alcohol Treatment Information	❒Emergency Department Records
❒Radiology Reports	❒Discharge summary	❒Other: _____

Purpose of the Disclosure: (Example: "At the request of the patient"): _____

_____

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this Authorization expires within sixty (60) days. Otherwise, you may select either of the following expiration events:

❒ 1 year from the date in which I, or my legal representative, signs this Authorization.

❒ Upon the happening of the following event: _____
(Example: "Upon release of the above records")

I understand that:

1. I may revoke this Authorization at any time by providing written revocation to Summit Urogynecology. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
2. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
3. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.
4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

Signatures: I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient (or Patient's Representative):	Date:
Print Name of Patient (or Patient's Representative):	

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

❒ Power of Attorney	❒Legal Guardian	❒ Surrogate Decision-Maker
❒ Executor or Personal Representative	❒ Parent	❒ Other: _____

For internal use only: Records were delivered by: ❒Fax ❒Mail ❒Personal Delivery on the date of: _____

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please notify Summit Urogynecology immediately.