



Dear Patient:

Welcome to our practice. In order to provide you with the most effective medical care, our office needs certain basic information regarding your medical history. The time you spend completing the enclosed forms will be an important contribution to your overall health care. Answer all questions to the best of your ability. A member of our health care team will review these with you and answer any questions you may have at the time of your appointment.

Please present the completed forms to the receptionist on the day of your visit. A copy of your insurance card will be taken so we may submit your claim(s) properly. If your insurance company requires a referral, it is the patient's responsibility to arrange for this prior to all appointments. Insurance co-payments are due at the time of service.

Lincoln Center OB/GYN will submit your claims when provided with the required information. Please remember, this is done as a courtesy for our patients. You are responsible for payment of your account. Your health care policy is a contract between you and your insurance company and/or employer.

Billing statements are mailed every twenty-eight days and are due upon receipt unless prior arrangements have been made with the business office. If the balance remains unpaid and no satisfactory payment arrangements have been made, the account will be reviewed for possible further action. Please contact our business office with any questions regarding your account.

If you do not have medical coverage, we ask for payment of office charges at the time of service. Additional charges such as pathology will be billed by the facility rendering those services. Lincoln Center accepts payment in the form of cash, check, or Visa/MasterCard. Please speak with a member of our business office if additional information is needed.

The physicians and staff of Lincoln Center look forward to assisting you in achieving your health care goals.

Sincerely,

The Physicians and Staff of Lincoln Center

800 SW Lincoln Street, Topeka, Kansas 66606
ph. 785.233.5101 fax 785.233.1404
www.lincolncenterobgyn.com

2830 SW Urish Road, Topeka, Kansas 66614
ph. 785.273.4010 fax 785.273-8530
www.lincolncenterobgyn.com

PLEASE COMPLETE ALL PAGES ** SIGN AND DATE WHERE INDICATED

Chart Number _____

**IF DATE(S) UNKNOWN PLEASE
GIVE AN APPROXIMATE YEAR**

Name _____

Today's date ____/____/____

What do you want us to call you? _____

Date of birth ____/____/____

Your employer & job title _____

Primary Doctor _____

Spouse/Partner's name _____

Referring Doctor _____

Age _____ Height _____ Weight _____

Date of last Pap smear ____/____/____

Date of last mammogram ____/____/____

Date of last bone density scan ____/____/____

Date of last colonoscopy ____/____/____

CHIEF COMPLAINT: What is the main reason in detail for your visit today? (Please use back if more room is needed.)

HISTORY OF PRESENT ILLNESS

Location of the problem(s) _____

Are there any other associated signs or symptoms?

If yes, please explain: _____

Severity of the problem(s) (Circle one or more)

Mild Moderate Severe Stable Worsening Improving

Does anything help or make the problem(s) worse?

Moving around Standing up Lying on my side

Other _____

How long have you been suffering from this problem(s)?

Days _____ Weeks _____ Months _____

Other _____

Is the problem(s) constant or variable?

Comes and goes _____ Always there _____

Other _____

PAST MEDICAL HISTORY (Please use back if more room is needed, or attach list.)

| Illness / Date <u>(at least approximate year)</u> | Current Medication(s) and dose(s) | Allergies |
|---|-----------------------------------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

SURGICAL HISTORY

Surgery / Date (at least approximate year)

OBSTETRIC HISTORY

Number of:

Pregnancies _____ Term deliveries _____

Preterm deliveries _____ Abortions _____

Ectopics _____ Miscarriages _____

Living Children _____

How many cesarean sections _____

Complications: _____

GYNECOLOGIC HISTORY

Last menstrual cycle: ____/____/____

If Menopausal, how long? _____

Current form of contraception: _____

Have you ever had an abnormal Pap? Yes when _____ No

Have you ever had pre-cancer of the cervix? Yes No

Have you ever had a sexually transmitted disease? Yes No

If yes, which one: _____

Have you ever had sex? Yes No

Are you sexually active now? Yes No

Family History

Please circle Yes if a Family Member has or had one of these illnesses:

| Illness: | Yes / No | Family Member: |
|------------------------|----------|----------------|
| Heart problems/disease | Yes / No | _____ |
| Diabetes | Yes / No | _____ |
| Stroke | Yes / No | _____ |
| Breast Cancer | Yes / No | _____ |
| Colon Cancer | Yes / No | _____ |
| Ovarian Cancer | Yes / No | _____ |
| Uterine Cancer | Yes / No | _____ |
| High blood pressure | Yes / No | _____ |
| Drinking problem | Yes / No | _____ |
| Other _____ | Yes / No | _____ |

Social History

Do you smoke, how many years and how much? Yes No Amount _____

Do you drink alcohol, how much per week? Yes No Amount _____

Do you use recreational drugs? (Marijuana, Cocaine...) Yes No Amount _____

Do you exercise regularly, how much? Yes No

Amount _____

Has anyone close to you ever threatened to hurt you? Yes No

Has anyone ever hit, kicked, choked, or hurt you physically? Yes No

Has anyone, including your partner, ever forced you to have sex? Yes No

Are you ever afraid of your partner? Yes No

Is there anything else you would like to tell us about? _____

LINCOLN CENTER OB & GYN, PA

Central Office:
800 SW Lincoln St
Topeka, KS 66606

West Office:
2830 SW Urish Rd
Topeka, KS 66614

Chart Number: _____ Doctor Number: _____

PATIENT INFORMATION (Please notify our office of any changes in the following information)

Name: _____
Last First Middle Suffix

Address 1: _____
(If P.O. Box, WE MUST ALSO HAVE HOUSE ADDRESS)

Address 2: _____
City State Zip

Social Security Number Date of Birth Referring Doctor Primary Care Dr.

Home Phone Work Phone Ext Fax # Cell Phone or email

Employer Occupation How Long?

Spouse / Parent's Name – (or nearest friend / relative) Their Social Security No. How Related?

Their Home Phone Their Work Phone Ext Their Employer

INSURANCE INFORMATION (if Blue Shield, specify if Choice Care, Blue Select, CAP Plus or Premier Blue) IF INSURANCE REQUIRES A REFERRAL, PLEASE HAVE IT WITH YOU OR HAVE YOUR DOCTOR MAIL TO US

Health Insurance Company No. 1 Effective Date Policy ID No. Group No.

Name policy is under Suffix Date of Birth Employer Sex

Health Insurance Company No. 2 Effective Date Policy ID No. Group No.

Name policy is under Suffix Date of Birth Employer Sex

OFFICE CREDIT POLICIES:

Payment is requested when service is rendered. OB patients without insurance must have their estimated fee paid in full by delivery date.

I hereby assign benefits from Medicare/Medigap/Medicaid/my Health Insurance(s) to the Lincoln Center OB-GYN, P.A., Doctors Morrison, Field-Kresie, Trobough, Gleason, Dickson, Bonebrake, Babin and Teply for all services billed to Medicare/Medigap/Medicaid/my Health Insurance Company(s) for which I have not paid in full. A copy of this assignment shall be as valid as an original.

I understand I will be financially responsible for any services considered to be non-covered by Medicare/Medigap/Medicaid/my Health Insurance. If my account is turned over to a collection agency, I understand that I may be subject to interest charges.

I authorize the release of any medical information necessary to process my claims, and for Utilization Review/Chart Audits that may be required under the guidelines of my insurance company.

It is understood and agreed that the physicians of Lincoln Center OB-GYN, P.A. have the right to designate which doctor(s) will perform medical services requested by the undersigned patient.

Date: _____

Signed: _____

Permission to Discuss Private Health Information

Through the 1996 Health Insurance Portability and Accountability Act, the Department of Health and Human Services established national standards for among other things, the privacy of protected health information. In compliance with these Federal regulations, **Lincoln Center** may not discuss your medical care with anyone without your express written permission, except in the case of an emergency or as required by law. This does not apply to disclosing information to carry out treatment, payment, or health care operations.

List below the full names of people with whom you give **Lincoln Center** permission to discuss your case, i.e. medication refills, test results, appointment scheduling, billing information, medical history, etc. Examples include: *subscriber of insurance, family member, interpreter, etc. If you choose not to name anyone, please indicate no one.

1. _____

2. _____

3. _____

* _____ Subscriber of Insurance may *ONLY* receive claims and payment information

Please list subscriber of insurance here, (if other than patient)

**To file claims to your insurance, the subscriber of insurance must be listed above. If you choose not to list the subscriber of your insurance, your account will be marked as "patient responsible for payment" and payment will be expected at the time of service.*

Signature

Date

Printed Name

Date of Birth

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of **Lincoln Center's** Notice of Privacy Practices with an effective date of April 14, 2003.

Signature (patient or patient's representative)

Date

(Relationship to patient)

Hipaa Release

LINCOLN CENTER OB/GYN PA

NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Lincoln Center is required by federal and state privacy laws to:

- Maintain the privacy of your health information
- Provide this notice describing our duties, privacy practices and your rights concerning your health information
- Abide by the terms of this Notice while it is in effect – This Notice takes effect April 14, 2003
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information about you

Lincoln Center reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. If our privacy practices and the terms of this Notice change, we will amend our Notice and make it available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following are examples of the types of uses and disclosures of your private health information that may be made by our office and are not meant to be exhaustive:

Treatment: We may use or disclose your private health information to a physician or other healthcare provider providing treatment to you or becomes involved in your care by providing assistance with your health care diagnosis.

Payment: We may use and disclose your private health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your private health information in order to support the business activities of Lincoln Center. Healthcare Operations include quality assessment and improvement activities, evaluating healthcare professional's performance, conducting training programs, accreditation, certification, licensing or credentialing activities, among others.

Your Authorization: Other uses and disclosures of your private health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

Communication with family: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care, about your location, and about your general condition, or death. In the event of your incapacity or emergency circumstances we will only disclose health information relevant to the person's involvement in your healthcare.

Coroners, Funeral Directors: We may disclose your private health information to coroners or funeral directors consistent with applicable laws to allow them to carry out their duties.

FDA, Health Oversight, Public Health: We may provide your private health information 1) to the Federal Drug Administration relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements 2) to appropriate health oversight agencies or for health oversight activities 3) to public health or legal authorities charged with preventing or controlling disease, injury, or disability (as required by law).

Fundraising, Marketing: We may contact you 1) as part of a fundraising effort 2) to provide you with appointment reminders, information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Legal Proceedings, Law Enforcement, Incarceration: We may disclose your private health information 1) in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, to the extent that the disclosure is expressly authorized 2) for law enforcement purposes as required by law such as by court order, in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement 3) if you are an inmate of a correctional facility as necessary for your health and the health and safety of other individuals.

Military Activity, National Security: We may disclose your private health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Research: We may disclose information to researchers with your authorization when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your private health information.

Workers' Compensation: If you are seeking compensation through Workers' Compensation, we may disclose your private health information to the extent necessary to comply with the laws relating to Workers Compensation.

LINCOLN CENTER OB/GYN PA NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS

The health and billing records we maintain are the physical property of Lincoln Center OB-GYN. The information in it however belongs to you. You have a right to:

Inspect a copy your private health information: You may ask to inspect a copy of your private health information up to those records permitted by law. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. Unless specifically indicated, only up to the last three years of records will be copied. Quality Copy Service, the clinic's copying service, will bill all patients \$18.18 for the first 30 pages, then \$.60 cents per page up to 250 pages and additional pages beyond 250 at \$.43 cents per page, plus applicable postage for all copies produced for this purpose. These fees are set annually by the State of Kansas Secretary of labor. Copying fees must be collected prior to surrendering records.

Request a restriction of your private health information: You may ask for additional restrictions on our use or disclosure of your private health information. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. We are not required to agree to a request, but will consider any reasonable requests made. You have the right to appeal our decision to deny access to your private health information except in certain circumstances. We are not required to agree to a restriction upon appeal.

Request alternative communication: You may request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request. We are not required to agree to a request, but will consider any reasonable request made.

Request an amendment: You may request that we amend your private health information by delivering the request in writing to our office using the form we provide to you upon request. We are not required to agree to a request, but will consider any reasonable request made. You have the right to appeal our decision to deny an amendment to your private health information by delivering the request in writing to our office using the form we provide to you upon request. We are not required to agree to an amendment upon appeal.

Request an accounting of disclosures: You have the right to receive a list of disclosures of your private health care information that occurred after April 14, 2003 by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal or external uses of information for treatment, payment or healthcare operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care, or disclosures required by law.

QUESTIONS AND COMPLAINTS

If you have questions, would like additional information, want to report a problem regarding the handling of your information, believe your privacy rights have been violated or want to file a complaint, you may contact either:

Administrator
Lincoln Center OB/GYN
800 SW Lincoln Center
Topeka, KS 66606
(785)233-5101

or

Operations Manager
Lincoln Center OB/GYN
800 SW Lincoln Center
Topeka, KS 66606
(785)233-5101

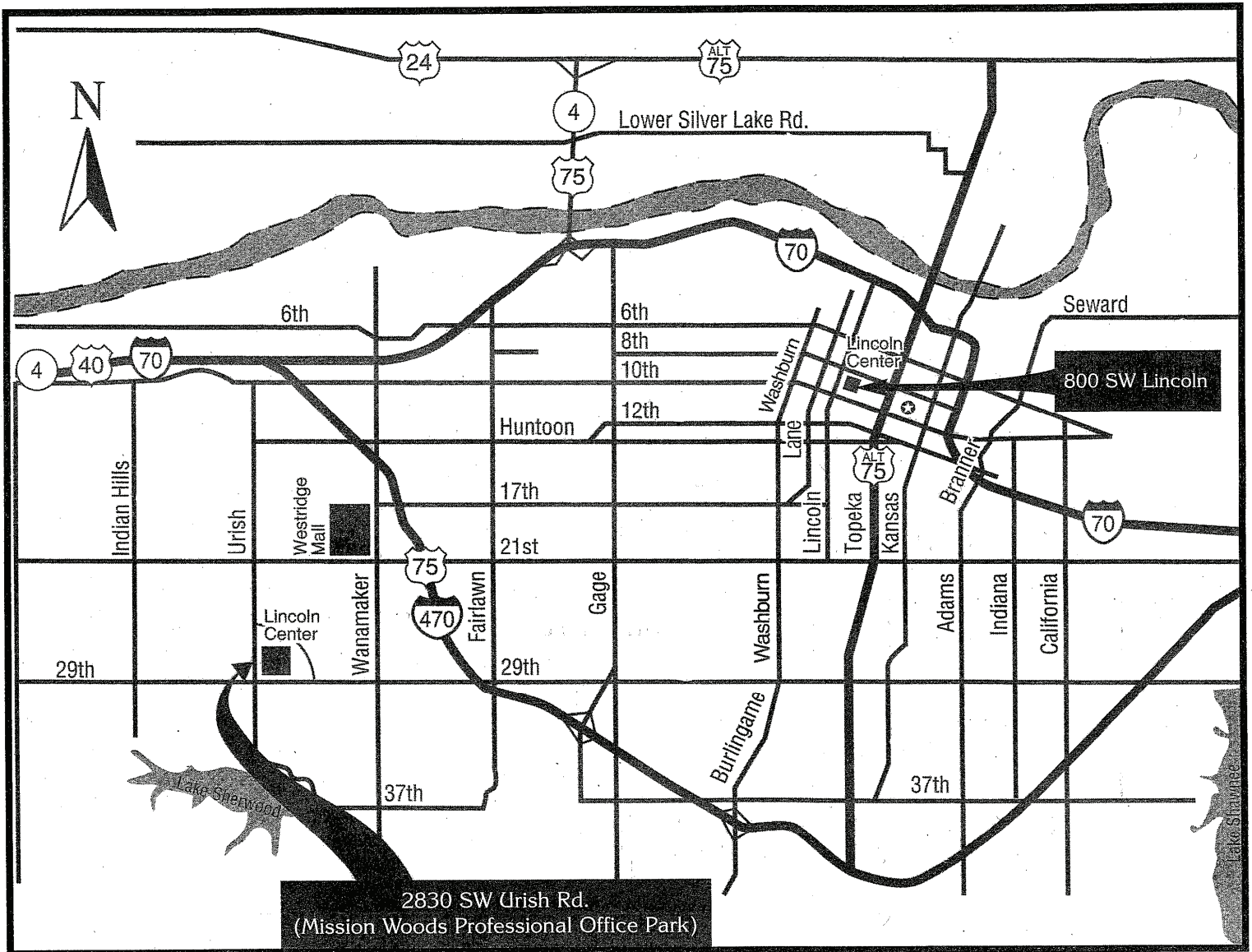
He or she will provide you with assistance on the steps you need to take to exercise your rights.

- We cannot, and will not, require you to waive the right to file a complaint with the Office for Civil Rights or US Department of Health and Human Services as a condition of receiving treatment from Lincoln Center OB/GYN.
- We cannot, and will not, retaliate against you for filing a complaint. You may file such complaints in writing to the following address:

A copy of this Privacy notice can be found at our website www.lincolncenterobgyn.com

Region VII, Office for Civil Rights
US Department of Health and Human Services
601 East 12th Street—Room 248
Kansas City, MO 64108

Voice Phone (816)426-7278
FAX (816)426-3686
TDD (816)426-7065
E-mail OCRComplaint@hhs.gov



DRIVING DIRECTIONS TO OUR TWO TOPEKA LOCATIONS

DOWNTOWN OFFICE:

800 S.W. Lincoln Street, Topeka, KS 66606

Our downtown office is centrally located between both area hospitals on 8th Street. We are three blocks east, on the southeast corner of Lincoln Street.

WEST OFFICE:

2830 S.W. Urish Road, Topeka, KS 66614

Our west office is located in southwest Topeka. We are just minutes away from the West Ridge Mall; take 21st Street west from the mall to Urish Road and turn left (south). We are located on the northwest corner of the Mission Woods Business Park.