Lincoln Center
OBSTETRICS & GYNECOLOGY, P.A.

CENTRAL OFFICE:
800 SW Lincoln St, Topeka, KS 66606
ph. 785-233-5101 fax 785-233-1404

URISH OFFICE:
2830 SW Urish Rd, Topeka, KS 66614
ph. 785-273-4010 fax 785-273-8530

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

PLEASE COMPLETE ALL PAGES ~ SIGN AND DATE WHERE INDICATED

IF DATE(S) UNKNOWN PLEASE GIVE APPROXIMATE YEAR

Today's date_____ Date of birth_____ Chart number_____

Name_____ Primary Doctor_____

What do you want us to call you?_____ Referring Doctor_____

Your employer & job title_____ Date of last Pap-smear_____

Spouse/Partner's name_____ Date of last mammogram_____

Age_____ Height_____ Weight_____ Date of last bone density scan_____

Date of last colonoscopy_____

CHIEF COMPLAINT

(please use back if more room is needed, or attach list)

What is the main reason in detail for your visit today?_____

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) *check 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 *at least approximate year*	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_____

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:			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	_____

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 afraid of your partner? __YES __NO

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

_____

_____

Other_____ __YES __NO _____ _____

Patient_____ DOB_____ Chart #_____

******Please circle yes to any symptoms present in the last 30 days*****

Constitutional

Weight Loss	Yes
Weight Gain	Yes
Fever	Yes
Fatigue	Yes

Cardiovascular/Respiratory

Difficuly Breathing	Yes
Swelling of Legs	Yes
Palpitations of heart	Yes

Musculoskeletal

Muscle Weakness	Yes

Skin/Breast

Rash	Yes
Pain in Breast	Yes
Nipple discharge	Yes
Lumps/Masses in breast	Yes

Endocrine

Hot Flashes	Yes
Too hot/cold	Yes

Allergic/Immunologic

Allergies/Hay Fever	Yes

Gastrointestinal

Nausea/Vomiting	Yes
Blood in Stool	Yes
Abdominal Pain	Yes
Constipation	Yes

Genitourinary

Problems getting pregnant	Yes
Blood in Urine	Yes
Pain with Urination	Yes
Urgency to Urinate	Yes
Frequency of Urination	Yes
Painful Intercourse	Yes
Unintended urine loss	Yes
Abnormal discharge	Yes
Abnormal periods	Yes
Painful Periods	Yes
PMS	Yes

Psychiatric

Are you generally satisfied with life	Yes
Depression	Yes
Have you considered suicide	Yes

Hematologic/Lymph

Frequent bruises	Yes
Enlarged Lymp nodes	Yes

Comments:

OBSTETRIC PATIENT SELF-HISTORY

PLEASE ADDRESS ALL QUESTIONS

If dates aren't known, please give an approximate year

PATIENT_____ DATE OF BIRTH_____ DOCTOR_____

RACE: ____White ____Black ____Other MARITAL STATUS: ____Married ____Single ____Widowed ____Divorced

What is your Spouse/Partner's Occupation/Job Title?_____

PAST PREGNANCIES

DATE:	SEX *check one*:	BIRTH WGT:	TERM *check one*:	DELIVERY *check one*:	COMPLICATIONS:
_____	__Male __Female	_____	__Full __Premature	__Vaginal __C/Section	_____
_____	__Male __Female	_____	__Full __Premature	__Vaginal __C/Section	_____
_____	__Male __Female	_____	__Full __Premature	__Vaginal __C/Section	_____
_____	__Male __Female	_____	__Full __Premature	__Vaginal __C/Section	_____

GENETICS SCREENING

Includes patient, baby's father, or anyone in either family with:

Will you be 35 or older at the time of delivery?	___YES ___NO
Italian, Greek, Mediterranean, or Oriental background?	___YES ___NO
Neural Tube Defect (meningomyelocele, open spine, or anencephaly)?	___YES ___NO
Down's Syndrome (Mongolism)?	___YES ___NO
Jewish (Tay Sach's)?	___YES ___NO
Sickle Cell Disease or Trait?	___YES ___NO
Hemophilia?	___YES ___NO
Muscular Dystrophy?	___YES ___NO
Cystic Fibrosis?	___YES ___NO
Huntington Chorea?	___YES ___NO
Mental Retardation?	___YES ___NO
Other inherited genetic or chromosomal disorder?	___YES ___NO
Patient or baby's father had a child with birth defect not listed above or three miscarriages or a stillbirth?	___YES ___NO
Medications or street drugs since last menstrual period	___YES ___NO

If yes, what drug(s)?_____

DATED:_____ **SIGNED:**_____ *Chart Number:*_____

LINCOLN CENTER
OBSTETRICS & GYNECOLOGY

*Chart Number:*_____

*Lincoln Center Physician:*_____

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

Name:_____ _____ _____ _____
Last First Middle Suffix

Address:_____
(IF PO BOX, **WE MUST ALSO HAVE HOUSE ADDRESS**)

City / State / Zip:_____ / _____ / _____

Social Security Number | Date of Birth | Marital Status | Primary Care Physician

Home Phone | Work Phone, Extension | Cell Phone | Referring Physician

Email Address | Employer | Occupation

Preferred Language

ETHNICITY:

____ **Hispanic or Latino**
____ **Not Hispanic or Latino**
____ **Decline to Answer**

RACE:

____ **American Indian or Alaska Native**
____ **Asian**
____ **Black or African American**
____ **Native Hawaiian or Other Pacific Islander**
____ **White**
____ **Decline to Answer**

Name of Parent, Spouse, Nearest Friend or Relative

How Related

Their Home Phone | Their Work Phone, Extension | Their Cell Phone

IF INSURANCE REQUIRES A REFERRAL, PLEASE HAVE IT WITH YOU OR HAVE IT MAILED TO US

Health Insurance Company (Primary) | Effective Date | Policy ID Number | Group Number

Name Policy is Under | Their Date of Birth | Their Employer | Their Sex

Health Insurance Company (Secondary) | Effective Date | Policy ID Number | Group Number

Name Policy is Under | Their Date of Birth | Their Employer | Their 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 physicians, Trobough, Gleason, Dickson, Teply, Morrison and Brey 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 company(s). 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 Medicare/Medigap/Medicaid/my health insurance company(s). It is understood and agreed that the physicians of Lincoln Center OB/GYN, PA have the right to designate which practitioner(s) will perform medical services requested by the undersigned patient.

DATED: _____ **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, HIPAA privacy reforms mandated by the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH) and Kansas law, **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 or under other limited circumstances described further in our Notice or Privacy Practices.

List below the full names of people with whom you give **Lincoln Center** permission to discuss your case, things such as medication refills, test results, appointment scheduling, billing and payment information, medical history, etc. Examples might include: family member, friend, interpreter, etc. If you choose not to name anyone, please write "NO ONE" below.

1. _____

2. _____

3. _____

***** *Subscriber of Insurance*: In order to file claims to your insurance, the subscriber of insurance must be listed as a person with whom you give **Lincoln Center** permission to discuss your case. If you choose not to list the subscriber of insurance below, your account will be marked as "patient responsible for payment" and payment will be expected at the time of service. To restrict the subscriber of insurance to only receive claims and payment information, please initial here: _____
Initials

_____
SUBSCRIBER OF INSURANCE

_____ _____
SIGNATURE Date

_____ _____
Printed Name Date of Birth

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Lincoln Center OB/GYN's Notice of Privacy Practices, with an effective date of April 14, 2003, **revision date September 23, 2015.**

_____ _____
SIGNATURE (patient or patient's representative) Date

_____
Relationship to patient

LINCOLN CENTER OB/GYN, PA – 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 IT CAREFULLY.

WHY ARE WE PROVIDING THIS NOTICE

Lincoln Center OB/GYN, PA compiles information relating to you and the treatment and services you receive. This information is called protected health information (PHI) and is maintained in a designated record set. We may use and disclose this information in various ways. Sometimes your agreement or authorization is necessary for us to use or disclose your information and sometimes it is not. This Notice describes how we use and disclose your protected health information and your rights. We are required by law to give you this Notice, and we are required to follow it. We may change this Notice at any time if the law changes or when our policies change. If we change the Notice, you will be given a revised Notice. You may also access this Notice on our website: www.lincolncenterobgyn.com.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

For Treatment: We may use and disclose your protected health information to give you medical treatment or services and to manage and coordinate your medical care. For example, your protected health information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

For Payment: We may use or disclose your protected health information so that we can bill for the treatment or services you receive from us and can collect payment from you, a health plan, or a third party. This may include disclosing information so that your health insurance plan may approve or pay for health care services we recommend for you, (e.g. making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities).

For Health Care Operations: We may use and disclose your protected health information when it is necessary for us to function as a business. For example, when we contract with other businesses to do specific tasks for us, we may share your protected health information related to those tasks. When we do this, the business agrees in the contract to protect your health information and use and disclose such health information only to the extent Lincoln Center OB/GYN, PA would be able to do so. These businesses are called Business Associates. Another example is if we want to see how well our staff is doing, we may use your protected health information to review their performance.

Appointment Reminders, Treatment Alternatives, Health-Related Benefits and Services: We may use and disclose protected health information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose your protected health information for medical research. All research projects however, are subject to a special approval process. Before we use or disclose your health information for research, the project will have been approved.

As Required by Law: We will disclose your protected health information when the law requires us to do so.

To Avert a Serious Threat to Health or Safety: We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ and Tissue Donation: If you are an organ or tissue donor, we may use or disclose your protected health information to an organ donation bank or other organizations that handle organ procurement to assist with organ or tissue donation or transplantation.

Military and Veterans: The protected health information of members of the United States Armed Forces or member of a foreign military may be disclosed as required by military command authorities.

Workers' Compensation: We may use or disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injury or illness.

Public Health Risks: We may disclose your protected health information for public health activities which include the prevention or control of disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or products; to notify people of recalls of devices or products; to notify persons who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. If you agree, we can provide immunization information to schools.

Health Oversight Activities: We may disclose protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.

Legal Proceedings: We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met for law enforcement purposes.

National Security and Intelligence Activities: When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.

Coroners, Medical Examiners, and Funeral Directors: We may disclose protected health information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates or Persons in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if the disclosure is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.

Effective Date: April 14, 2003
Revision Date: September 23, 2015

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT OR OPT OUT

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your protected health information to disaster relief organizations that seek your protected health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures: Uses and disclosures of your protected health information for marketing purposes or that constitute a sale of your protected health information, will be made only with your written authorization. Other uses and disclosures of protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our office and we will no longer disclose protected health information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Access: You have the right to inspect and obtain a copy of your protected health information. We have up to 30 days to make your protected health information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: You have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity if your protected health information is maintained in an electronic format. We will make every effort to provide access to your protected health information in the form or format you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Notice of a Breach: You have a right to be notified upon a breach of any of your unsecured protected health information.

Right to Request Amendments: If you feel that the protected health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to our Privacy Officer at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures: You have a right to an accounting of disclosures of your protected health information that is maintained in a designated record set. This is a list of persons, government agencies, or businesses who have obtained your health information. There are specific time limits on such requests. You have the right to one accounting per year at no cost.

Right to Request Restrictions: You have the right to ask us to restrict disclosures of your protected health information. If you self-pay for a service and do not want your health information to go to a third party payor, we will not send the information, unless it has already been sent, you do not complete payment, or there is another specific reason we cannot accept your request. For example, if your treatment is a bundled service and cannot be unbundled and you do not wish to pay for the entire bundle, or the law requires us to bill the third party payor (e.g., a governmental payor), we cannot accept your request. We do not have to agree to any other restriction. If we have previously agreed to another type of restriction, we may end that restriction. If we end a restriction, we will inform you in writing.

Right to Request Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice, even if you have agreed to receive it electronically. You may request a copy from our office or you may go to our website at www.lincolncenterobgyn.com.

Right to File a Complaint: If you believe your privacy rights as described in this Notice have been violated, you may file a written complaint with our Privacy Officer at the address listed at the end of this Notice, or with the U.S. Department of Health and Human Services, Office for Civil Rights by email at www.hhs.gov/ocr/privacy/hipaa/complaints/index.html, or the Regional Office in Kansas City, 601 E 12th Street Room 248, Kansas City MO 64106, 816-426-7277. You will not be penalized for filing a complaint.

How to Exercise Your Rights: To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. We may ask you to fill out a form that we will supply.

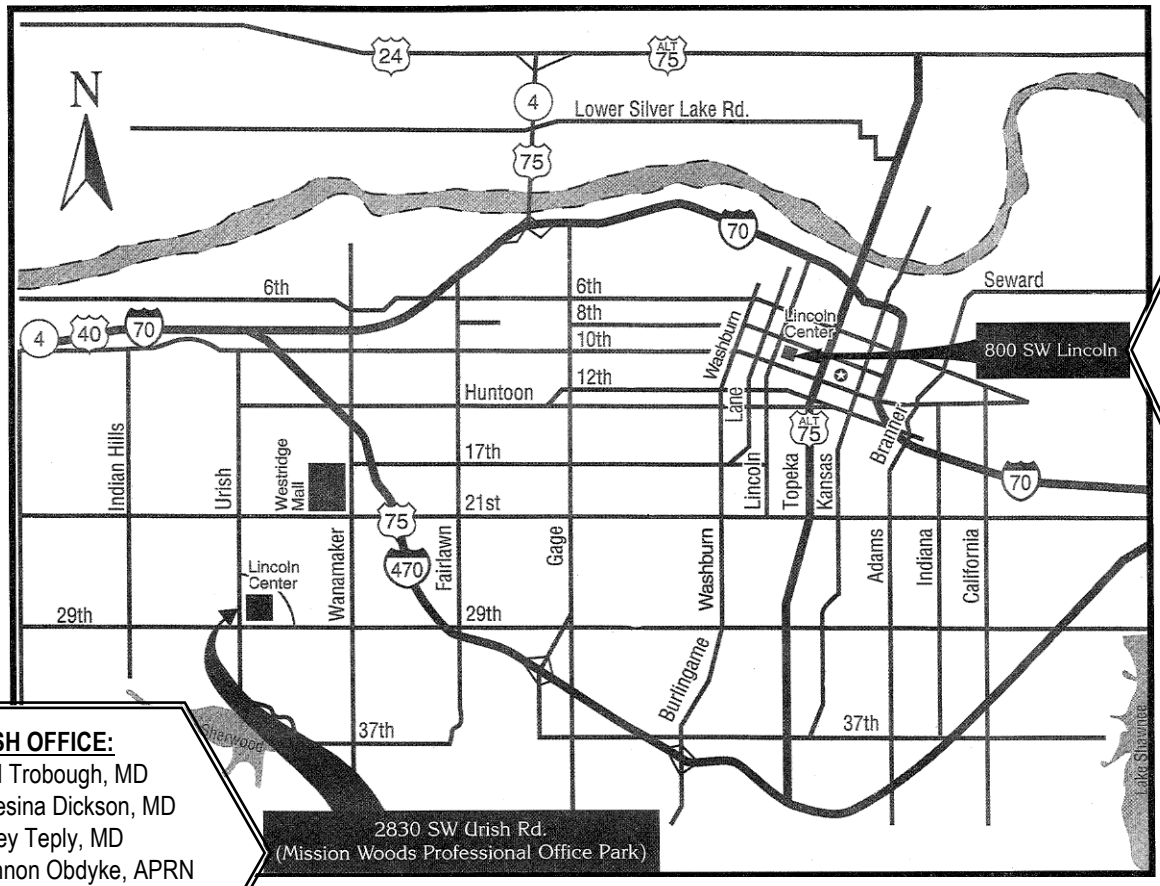
CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for protected health information that we currently maintain in our possession, as well as for any protected health information we receive, use, or disclose in the future. A current copy of the Notice will be posted in our facilities.

If you have any questions about this Notice or if you need more information, please contact our Privacy Officer at:

Lincoln Center OB/GYN, PA
800 SW Lincoln St
Topeka, KS 66606-1515
Phone: 785-233-5101
Facsimile: 785-233-1404

Effective Date: April 14, 2003
Revision Date: September 23, 2015



CENTRAL OFFICE:
Douglas Gleason, MD
Heather Morrison, MD
Kimberly Brey, MD
Leslie Arnold, CNM
Beth Kamprath, CNM
Chandra Case, CNM

URISH OFFICE:
Todd Trobough, MD
Jamesina Dickson, MD
Jeffrey Teply, MD
Shannon Obdyke, APRN
Leslie Arnold, CNM
Beth Kamprath, CNM
Chandra Case, CNM

DRIVING DIRECTIONS TO OUR TWO TOPEKA LOCATIONS

URISH OFFICE:

2830 SW Urish Rd, Topeka KS 66614
(785) 273-4010

Our Urish 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.

CENTRAL OFFICE:

800 SW Lincoln St, Topeka KS 66606
(785) 233-5101

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