Welcome to Northwest Obstetrics & Gynecology Associates, Inc.

Thank you for choosing Northwest Obstetrics & Gynecology Associates, Inc to participate in your care.

This New Patient packet has all the forms required for your initial visit to our practice. If you like, you may complete some of the forms online via our patient portal.

If you do not wish to visit the patient portal you may complete the attached forms and print them off, or print and complete them by hand. We ask that you bring the completed attached forms along with your insurance card, photo id and any co-pay that may be applicable with you to your first appointment. Please arrive 20-30 minutes prior to your appointment time. This will help ensure that you are taken back in a timely manner.

If you do not arrive 20-30 minutes early and/or the paperwork has not been completed, you may be asked to reschedule.

Northwest Obstetrics & Gynecology
3841 Trueman Ct.
Hilliard, OH 43026

Phone: 614-777-4801
Fax: 614-777-8644

Monday - Friday 8:30am - 4:30pm

NORTHWEST OBSTETRICS & GYNECOLOGY ASSOCIATES, INC

3841 Trueman Ct., Hilliard, OH 43026 Phone (614) 777-4801 Fax (614) 777-8644

Patient Information

Full Legal Name (Last, First, Middle): ______________________________

Name you wish to be called: ______________ Email: ______________

Address ______________ City, State and Zip: ______________

Home Phone: __________ Work Phone __________ Cell Phone __________

Social Security Number: __________ Date of Birth: __________ Age: __________

Race: ________ Ethnicity: ________ Marital Status: __Single __Married __Widow __Divorced __Partner

Spouse Name __________ Date of Birth __________ SS# __________

If Patient is a minor who is responsible for charges

Name: ______________ ______________ Date of Birth: ______________

Address: ______________________________

City, State and Zip: ______________ Phone Number: ______________

Social Security Number: ______________ Relationship to patient: ______________

Emergency Contact

Name (Last, First, MI) ______________Relationship to patient: ______________

Home Phone: __________ Work Phone: __________ Cell Phone : __________

Medical Insurance (Must present insurance card at each visit)

Primary Insurance: ______________________________

Subscriber ______________ Date of Birth ______________

Social Security Number: ______________ Relationship to patient: ______________

Address: ______________________________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Secondary Insurance: ______________________________

Subscriber ______________ Date of Birth ______________

Social Security Number: ______________ Relationship to patient: ______________

Address: ______________________________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Do we have your permission to check pharmacy records? (Please)   Yes   No

Local Pharmacy

Pharmacy Name ____ Phone __________________________

Address ____

Mail Order Pharmacy

Pharmacy Name ____ Phone _________________________

Address ____

Do we have your permission to call you? (Please check)   Yes   No

Do we have your permission to text you? (Please check)   Yes   No

<u>Authorization and Release</u>

Patients 18 years and older are responsible for their own accounts regardless of who carries the insurance policy.

I understand it is my responsibility to verify with my insurance company if any and all services are covered and/or require preauthorization. I understand that if I have a co-pay it is payable at the time of service. If I do not have insurance coverage, I understand that payment is due at the time of service. I understand that if inaccurate insurance information is given to Northwest OB/GYN and the information is not corrected until after my insurance company's timely filing limit, I will be responsible for the bill. I hereby assign all medical and/or surgical benefits, to include major medical benefits of which I am entitled, including Medicare, private insurance and any other health plan to Northwest Obstetrics & Gynecology Associates, Inc. This assignment will remain in effect until revoked by me in writing. I authorize a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges whether covered/paid or not covered/paid by my insurance. I hereby authorize Northwest Obstetrics & Gynecology Associates, Inc. to release all information necessary to secure payment.

____________________________________	____________	__ __________________________	_____________
Signature of Patient	Date	Signature of Guarantor If patient is a minor	Date

Northwest Obstetrics & Gynecology Associates, Inc.

APPOINTMENT OF PERSONAL REPRESENTATIVE
TO RECEIVE PROTECTED HEALTH INFORMATION

You may rely upon your spouse, relatives or friends from time to time to understand your treatment options, visit your physicians, acquire prescriptions, get test results, and otherwise be involved in your medical care. However, federal law does not allow us to Disclose any of this information to these people unless you appoint them as your "personal representatives".

To appoint an Individual as your personal representative, complete this form.

I hereby authorize NORTHWEST OB/GYN to release the following protected health information to the Individual I have designated:

Name	Relationship	Personal Health Information That May Be Disclosed
	☐ Spouse ☐ Other Relative ☐ Friend ☐ Other Date of Birth __________	☐ All personal health information OR One or more of these choices: ☐ Times of appointments ☐ Prescriptions & ancillary equipment ☐ Test results ☐ Copies of medical records ☐ Other:
If you wish to designate more than one Individual, use an additional form.		

I may revoke this appointment at any time. My revocation will NOT affect any actions that have been already taken in reliance on my original appointment.

____ Date:_____________________
Individual's Printed Name

____
Individual's Signature

Individual's Address: ____
____
____

Northwest Obstetrics & Gynecology Associates, Inc.

REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS AT AN ALTERNATIVE LOCATION OR BY ALTERNATIVE MEANS

As stated in our Notice of Privacy Practices, you may request NORTHWEST OB/GYN to communicate confidential protected health information to you at an alternative location or by an alternative means. The HIPAA Privacy Rule requires us to accommodate your request(s), if reasonable. **Please indicate your request regarding the communication of protected health information to you:**

☐ Please do not call my home telephone number with confidential information.

☐ Please do not call my work telephone number with confidential information.

☐ Please do not leave messages on my telephone answering machine.

☐ If a telephone call is required, please use this number: ______________

☐ Please do not send confidential communications to my home address.

☐ Please do not send confidential communications to my work address.

☐ Please use this address to send confidential communications: ___________________________
☐ ____

☐ Please do not send confidential communications to my email address.

☐ Other (please explain): ____
☐ ____

If your Request involves billing information, please explain:

____

____

____
Print Name

____
Signature

____
Print Name of Individual's Personal Representative
(if signing for Individual)

____
Date Request Received
(to be completed by NORTHWEST OB/GYN)

____
Date

NORTHWEST OBSTETRICS AND GYNECOLOGY ASSOCIATES, INC.
Financial Policy

Patient Name ____ Date ____________________

Thank you for choosing us as your women's health care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   ~Bring your current insurance card to every visit and notify us of changes in coverage.
   ~We will submit a claim to your insurance company for you. Balance not paid, per our contract by your primary insurance company may be billed to your secondary payer. A monthly statement will be sent to you. ***Ultimately*** you are responsible for payment of charges.
   ~Be prepared to pay your copay at each visit. Payment can be made by cash, check, Mastercard, Visa or Discover.
   ~I understand that my insurance carrier can choose to assign benefits to Northwest Obstetrics and Gynecology Associates or my insurance carrier may make payment directly to me.
   ~I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible or charges for non-covered services provided to me or any of my dependents.
2. If you do not have insurance coverage or if you are insured by a company with which we are not contracted, payment in full is expected at the time of service unless payment arrangements are made and kept.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however should be directed to your insurance company member services department (number should be on your insurance card).
4. This office charges for all services that are significant and separately identifiable. Patient that are seen for physical exams and require other treatment for illnesses or problems may be charged separately for each service even when both services are provided on the same day.
5. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis be changed solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.
6. All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 are subject to our collection process.
7. There will be a fee charged for all appointments that were not kept and/or not cancelled 24 hours prior to the appointment time.
8. If you are 15 minutes late for your appointment you may be billed for a no show appointment and be asked to reschedule.
9. Co-pays not paid at the time of services may result in a processing fee of $30.00.
10. There is a $30.00 fee on all returned checks.
11. There is an additional fee for all office visits scheduled after posted hours. Emergency visits/walk-ins/nonscheduled appointment will be charged an additional fee.

Patient's Initials _______

12. There is a fee to copy any or all medical records. The fee is regulated by the State of Ohio.
13. There is a fee for FMLA and/or Disability forms. This is a per form fee and is to be paid prior to the forms completion.
14. Yearly well woman exams may or may not be covered under your health insurance policy, however, they may be required by your physician. Some prescriptions and forms may not be filled out/refilled/completed/or signed if physicals are not up to date.
15. If you miss or no show for three (3) appointments and /or are non-complaint you may be dismissed from the practice.
16. If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify Northwest OB/GYN to the contrary in writing. Calls and text messages include, but are not limited to: pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Northwest OB/GYN, its affiliates, contractors, clinical providers, attorneys, or its agents including collection agencies.
17. Refunds—All refunds will be issued by corporate check. Refunds will not be issued until all outstanding charges are paid in full. Our goal is that all refunds will be done on a weekly basis.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, I certify that I will pay Northwest Obstetrics and Gynecology Associates, Inc, any co-payments, coinsurance, deductible or non-covered services. I will immediately pay to Northwest Obstetrics and Gynecology Associates, Inc. any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance because I have not provided the appropriate insurance information for billing.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if given false information, withhold information or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

____ ______________________________

Print Patient's Name Date

Signature of Patient or Guardian

FP 2/23/17

Northwest Obstetrics & Gynecology Associates, Inc

3841 Trueman Ct Hilliard, OH 43026

614-777-4801 Fax 614-777-8644

MEDICAID WAIVER

Please be advised that this office does not accept Medicaid or any Medicaid product.

These services could be paid for by Medicaid and or any Medicaid product if you were to see a physician that is a provider for those plans. If you wish to receive services at this office you will be financially responsible for all charges incurred.

I understand that any services provided to me by Northwest Obstetrics & Gynecology Associates, Inc. will not be billed to Medicaid or any Medicaid product and that I am financially responsible for all charges incurred. I have been informed that if I see a Medicaid or any Medicaid product provider that the charges would most likely be covered.

I wish to continue and agree to pay any charges incurred.

____
Patient’s Name

____ ________________________
Patient’s Signature **Date**

____ ________________________
Witness Signature **Date**

Northwest Obstetrics & Gynecology Associates, Inc

H E A L T H   H I S T O R Y

Date of Visit ____
Patient's Name ____________________________________
Preferred Name ____________________________________
Physician (OB/GYN) _________________________________
Physician (Family/Internal)____________________________
Referred by __ Physician_____________________________
__ Family/Friend________________________
__ Other______________________________

New Patient Current Patient

Reason for visit

____
____
____
____

Age _______

Pregnancy History

Number of times pregnant ___________________
Miscarriages ______________________________
Ectopic __________________________________
Abortions ________________________________
Living children ____________________________

Menstrual History

Age menses started________________________
Regular monthly cycles __ Yes __ No
First day of last two menstrual periods
______________, _________________
Current method of contraception ________________
Are you sexually active ___ Yes ___ No
Previous STDs (sexually transmitted diseases)
____
____

Preventative Care

Date of last pap smear ________________________
Have you ever had an abnormal pap __ Yes __ No
When _________________________________
Date of last mammogram ______________________
History of abnormal mammogram __ Yes __ No
Date of last Cholesterol test (if > 35 y) ______________
Date of last colon cancer screening (> 50 y)__________
Date of last DEXA (bone scan) (> 50 y)______________
Vaccinations (year)
HPV series 1st _________ 2nd ________ 3rd _________
Measles, Mumps and Rubella (MMR)_______________
Flu ____
Tetanus _______________________________________
Pneumococcus (>65y)___________________________

Current **Medical Problems/Illnesses**

____
____
____

Surgeries/Injuries (include year if know)

____
____
____

Allergies to drugs

____
____

Medications you are currently taking

____
____
____

Social History

Married Single Divorced Widowed Partnered
Smoker __ Yes __ No __ Former # of packs per day ____, how many years ____
Alcohol __ Yes __ No # of drinks per week ________________
Have you ever used recreational/illegal drugs __ Yes __ No Type ________________
Have you ever had a blood transfusion __ Yes __ No When ____________________
Occupation ____
Do you exercise regularly __ Yes __ No Hours per week ____________

Family History -- Please place **F**=Father, **M**=Mother, **B**=Brother, **S**=Sister, **C**=Child, **MGM =** Maternal Grandmother, **MGF**= Maternal Grandfather, **PGM** = Paternal Grandmother, **PGF** = Paternal Grandfather next to any issue/problem.

Osteoporosis _____________________ Heart Disease ______________________
Diabetes________________________ High Cholesterol ____________________
High Blood Pressure _______________ Blood Clots _________________________
Stroke __________________________ Liver Disease ______________________
Breast Cancer ____________________ Genetic Disorder ____________________
Uterine Cancer ___________________ Thyroid Disorder ____________________
Cervical Cancer __________________ Other Cancers/Diseases______________
Ovarian Cancer ___________________ _______________________________
Colon Cancer _____________________ _______________________________

Review of systems (mark if you **currently** have symptoms or have had **frequently**)

__ Change in weight __ Blood in stool __Fever/chills
__ Fatigue/tiredness __ Blood in urine __ Change in vision
__ Difficulty hearing __ Burning with urination __ Wear glasses/contacts
__ Nasal drainage __ Incontinence of urine __ Vaginal discharge
__ Congestion __ Frequency/urgency __ Menstrual cramps
__ Sore throat __ Muscle/joint pain __ Pain with sex
__ Wheezing __ Muscle weakness __ Bleeding after sex
__ Cough __ Rash/change in mole __ Abnormal bleeding
__ Headache __ Numbness/tingling __ Breast mass/discharge
__ Dizziness/fainting __ Depression/anxiety __ Chest pains/palpitations
__ Swollen legs __ Constipation __ Shortness of breath
__ Varicose veins __ Diarrhea __ Abuse (current or history of)
__ Easy bruising __ Nausea/vomiting __ Jaundice/liver disease

REVIEWED BY ___________________________________ M.D.

HIPAA Notice of Privacy Practices
Northwest Obstetrics & Gynecology Associates, Inc.

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice applies to the Northwest Obstetrics & Gynecology Associates, Inc. (NORTHWEST OB/GYN). The purpose of this Notice is to describe how NORTHWEST OB/GYN may use and disclose your protected health information ("PHI") in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") and the HIPAA Omnibus Final Rule (the "Final Rule"). This Notice also describes the obligations of NORTHWEST OB/GYN with respect to your protected health information, describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operations, and describes your rights to control and access your protected health information. NORTHWEST OB/GYN has agreed to the provisions set forth in this Notice.
We are required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

(a) your past, present, or future physical or mental health or condition;
(b) the provision of health care to you; or
(c) the past, present, or future payment for the provision of health care to you.

1. Responsibilities of NORTHWEST OB/GYN.

NORTHWEST OB/GYN is required under HIPAA to maintain the privacy of your protected health information. Protected health information includes all individually identifiable health information transmitted or maintained by NORTHWEST OB/GYN that relates to your past, present or future health, treatment or payment for health care services. NORTHWEST OB/GYN must abide by the terms of this Notice, and must provide you with a copy of this Notice upon request.

2. How NORTHWEST OB/GYN May Use and Disclose Your Protected Health Information.

The following categories describe the different situations in which NORTHWEST OB/GYN is permitted or required to use or disclose your protected health information:

- **For Treatment**. NORTHWEST OB/GYN may use or disclose your protected health information to facilitate medical treatment or services by providers. NORTHWEST OB/GYN may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.
- **For Payment Purposes**. NORTHWEST OB/GYN has the right to use and disclose your protected health information to satisfy their responsibilities with respect to the billing and payment collected from you, an insurance company or a third party, for treatment and services you receive from NORTHWEST OB/GYN. For example, NORTHWEST OB/GYN may need to give your health plan information about therapy or nursing services you receive in order to receive reimbursement from your health plan for those services. NORTHWEST OB/GYN may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **Health Care Operations**. NORTHWEST OB/GYN has the right to use and disclose your protected health information to perform functions necessary for the operation of NORTHWEST OB/GYN. For example, NORTHWEST OB/GYN may use health care information to review Northwest OB/GYN's treatment and services and to evaluate the performance of our staff in caring for you. NORTHWEST OB/GYN may combine health care information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. NORTHWEST OB/GYN may also disclose information to doctors, nurses, therapists, technicians, aides, students and other NORTHWEST OB/GYN personnel for review and learning purposes. NORTHWEST OB/GYN may remove information that identifies you from the health care information so others may use it to study health care and health care delivery without learning the identity of any specific patient.
- **Appointment Reminders**. NORTHWEST OB/GYN may use and disclose health care information to contact you as a reminder that you have an appointment with NORTHWEST OB/GYN.
- **Treatment Alternatives**. NORTHWEST OB/GYN may use and disclose health care information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services**. NORTHWEST OB/GYN may use and disclose health care information to tell you about health-related benefits or services that may be of interest to you.
- **To the Individual**. NORTHWEST OB/GYN may disclose protected health information, which you are the subject of, to you.
- **Individuals Involved in Your Care or Payment for Your Care**. NORTHWEST OB/GYN may release health care information about you to a friend or family member who is involved in your health care. NORTHWEST OB/GYN may also give information to someone who helps pay for your care. In addition, we may disclose health care information about you to

an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. This release requires written or oral consent from you.

- **Research**. Under certain circumstances, NORTHWEST OB/GYN may use and disclose health care information about you for research purposes. For example, a research project may involve comparing the health and recovery of all parties who received one type of treatment to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health care information, trying to balance the research needs with patients' need for privacy of their health care information. Before we use or disclose health care information for research, the project will be approved through this research approval process, but NORTHWEST OB/GYN may, however, disclose health care information about you to people preparing to conduct a research project, for example, to help them look for patients with specific health care needs, so long as the health care information they review does not leave our control. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care with us.

- **Business Associates**. NORTHWEST OB/GYN may contract with certain service providers ("Business Associates") to perform various functions on behalf of NORTHWEST OB/GYN. To provide these services, the Business Associates may receive, create, maintain, use or disclose protected health information. NORTHWEST OB/GYN and each Business Associate will enter into, or have already entered into, an agreement requiring the Business Associate to safeguard your protected health information as required by law and in accordance with the terms of this Notice.

- **Required by Law**. NORTHWEST OB/GYN may use or disclose your protected health information to the extent required by federal, state or local law. For example, NORTHWEST OB/GYN may disclose your protected health information when required by national security laws or public health disclosure laws.

- **Lawsuits and Disputes**. NORTHWEST OB/GYN may disclose your protected health information in response to a court or administrative order. Your protected health information may also be disclosed in response to a subpoena, discovery request or other lawful process if efforts have been made to tell you about the request or to obtain an order protecting your protected health information.

- **Certain Government Agencies and Officials**. NORTHWEST OB/GYN may disclose your protected health information to (i) government agencies involved in oversight of the health care system, (ii) government authorities authorized to receive reports of abuse, neglect or domestic violence, (iii) law enforcement officials for law enforcement purposes, (iv) military command authorities, if you are or were a member of the armed forces, (v) correctional institutions, if you are an inmate or in under the custody of a law enforcement official and (vi) federal officials for intelligence, counterintelligence, and other national security activities.

- **Public Health and Research Activities; Medical Examiners**. NORTHWEST OB/GYN may also disclose your protected health information (i) for public health activities or to prevent a serious threat to health and safety, (ii) to organizations that handle organ donations, if you are an organ donor, (iii) to coroners, medical examiners and funeral directors as necessary, and (iv) to researchers, if certain conditions regarding the privacy of your protected health information have been met.

- **Workers' Compensation**. NORTHWEST OB/GYN may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- **Military and Veterans**. If you are a member of the armed forces, NORTHWEST OB/GYN may release health care information about you as required by military command authorities. We may also release health care information about foreign military personnel to the appropriate foreign military authority.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services**. NORTHWEST OB/GYN may be required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services to investigate or determine NORTHWEST OB/GYN's compliance with the HIPAA Privacy Rules.

- **Other Uses and Disclosures with Written Authorization**. Disclosures and uses of your protected health information that are not described above may be made by NORTHWEST OB/GYN with your written authorization. If NORTHWEST OB/GYN is authorized to use or disclose your protected health information, you may revoke that authorization, in writing, at any time, except to the extent that NORTHWEST OB/GYN has taken action relying on the authorization. NORTHWEST OB/GYN will not be able to take back any disclosures of your protected health information that have already been made with your authorization.

- **Organized Healthcare Arrangement.** We participate in an organized healthcare arrangement through OhioHealth Group, Ltd. ($Health_4$). $Health_4$ consists of an organized system of healthcare in which multiple covered entities participate. Through $Health_4$, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of $Health_4$

- **Health Information Exchanges.** We participate in one or more Health Information Exchanges (HIE). Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the office administrator in writing.

3. Your Rights with Respect to Your Protected Health Information.

The following summarizes your rights with respect to your protected health information:

- **Right to Request a Restriction on Uses and Disclosures of Protected Health Information.** You have the right to request a restriction or limitation on the protected health information used or disclosed about you by NORTHWEST OB/GYN for treatment, payment or health care operations. You also have the right to request a limit on the disclosure of your protected health information to someone who is involved in your care or the payment for your care, such as a family member, friend or other person you have identified as responsible for your care. In your request, you must tell NORTHWEST OB/GYN (i) what information you want to limit; (ii) whether you want to limit NORTHWEST OB/GYN's use, disclosure, or both; and (iii) to whom you want the limits to apply, for example, disclosures to your spouse. NORTHWEST OB/GYN will comply with any restriction request if (iv) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (v) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full. If NORTHWEST OB/GYN agrees to your request, NORTHWEST OB/GYN will honor the restriction until you revoke it or we notify you.

- **Right to Request Confidential Communications**. You have the right to request that NORTHWEST OB/GYN communicate with you about your protected health information in a certain way or at a certain location. For example, you can request that NORTHWEST OB/GYN only contact you at work or by mail. NORTHWEST OB/GYN will accommodate all reasonable requests.

- **Right to Inspect and Copy Your Protected Health Information**. You have the right to inspect and copy your protected health information. Under certain limited circumstances, we may deny your access to a portion of your records. For example, you do not have a right to inspect and copy psychotherapy notes or information that NORTHWEST OB/GYN have collected in connection with, or in reasonable anticipation of, any legal claim or proceeding. If you request copies, we may charge you reasonable copying and mailing costs.

- **Right to Amend Your Protected Health Information**. You have the right to request an amendment of your protected health information that is maintained by NORTHWEST OB/GYN if you believe that the information is inaccurate or incomplete. NORTHWEST OB/GYN may deny your request if your protected health information is accurate and complete or if the law does not permit NORTHWEST OB/GYN to amend the requested information. NORTHWEST OB/GYN cannot amend information created by your doctor or any person other than NORTHWEST OB/GYN.

- **Right to Receive an Accounting of Disclosures of Your Protected Health Information.** You have the right to request an accounting of disclosures NORTHWEST OB/GYN has made of your protected health information during the six (6) years prior to the date of your request. However, you will not receive an accounting of (i) disclosures made more than six (6) years ago, (ii) disclosures made to you, (iii) disclosures made pursuant to your authorization, (iv) disclosures for purposes of treatment, payment or health care operations and (v) disclosures made to friends or family in your presence or because of an emergency. Certain other disclosures are also excepted from the HIPAA accounting requirements. If you request more than one accounting in any twelve (12) month period, NORTHWEST OB/GYN will charge you a reasonable fee for each accounting after the first accounting statement.

- **Uses and Disclosures that Require Your Authorization**. The following uses and disclosures will be made by NORTHWEST OB/GYN only with your authorization: o uses and disclosures for marketing purposes, including subsidized treatment communications;
  - uses and disclosures that constitute the sale of PHI;
  - if NORTHWEST OB/GYN maintains psychotherapy notes, the use and disclosure of such notes will only be made upon the authorization from you; and
  - other uses and disclosures not described in this Notice.

You may revoke your authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

- **Right to Opt-Out of Fundraising Communications**. If NORTHWEST OB/GYN conducts or engages in fundraising communications, you shall have the right to opt-out of such fundraising communications.
- **Right to Receive a Paper Copy of this Notice**. You have the right to receive a paper copy of this Notice upon request, even if you agreed to receive this Notice electronically. To obtain a paper copy of this Notice, contact the Privacy Officer at (614) 771-4801.
- **Right to Be Notified of a Breach**. You have the right to be notified in the event that NORTHWEST OB/GYN (or a Business Associate) commits or discovers a breach of unsecured protected health information.
- **To Exercise Your Individual Rights**. To exercise any of your rights listed above, you must complete the appropriate form. To obtain the required form, please contact the Privacy Officer at (614) 777-4801.

4. **Filing a Complaint with NORTHWEST OB/GYN or the U.S. Dept. of Health and Human Services.**

If you believe that NORTHWEST OB/GYN has violated your HIPAA privacy rights, you may complain to NORTHWEST OB/GYN or to the Secretary of the U.S.
Department of Health and Human Services. Complaints to NORTHWEST OB/GYN should be sent to the Privacy Officer, Northwest Obstetrics & Gynecology Associates, Inc. 3841 Trueman Ct, Hilliard, OH 43026. Complaints to the Secretary should be sent to the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, D.C. 20201. NORTHWEST OB/GYN will not penalize you or retaliate against you for filing a complaint.

5. **Changes to this Notice.**

NORTHWEST OB/GYN reserves the right to change the provisions of this Notice and to apply the changes to all protected health information received and maintained by NORTHWEST OB/GYN. If NORTHWEST OB/GYN makes a material change to this Notice, a revised version of this Notice will be provided to you within thirty (30) days of the effective date of the change at your address of record.

6. **Effective Date.**

This Notice becomes effective on May 1, 2018.

Northwest Obstetrics & Gynecology Associates, Inc.

Acknowledgement by Individual or Personal Representative of Receipt of Notice of Privacy Practices

I acknowledge receiving a copy of the Notice of Privacy Practices given to me by **NORTHWEST OB/GYN**.

I understand this Notice explains how **NORTHWEST OB/GYN** is permitted to Use and Disclose my Protected Health Information.

I understand I should keep the Notice and refer to it if I have questions. I also understand I should call the **NORTHWEST OB/GYN** Privacy Officer at 614-771-4801 if I have a question or concern about my privacy rights.

____

Print name of Individual

____

(If applicable) Print name of Individual's Personal Representative and Relationship to Individual

____ ____________________

Signature by Individual or Individual's Personal Representative **Date**

OFFICE STAFF USE ONLY IF ACKNOWLEDGMENT NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgment of Receipt:

- ☐ NPP given to Individual, who refused to sign.
- ☐ NPP was mailed to Individual's home address as stated in records.
- ☐ NPP was mailed to an alternate address, at Individual's request.
- ☐ NPP was faxed or emailed to Individual, at Individual's request.

Other reason(s) why written acknowledgment not obtained:

____ ____________________

Signature of Person attempting to obtain signed Acknowledgment Date

ORIGINAL MAINTAINED IN FILE

Patient Advocacy Program

The doctor and patient are desirous of entering into and/or maintaining a positive physician/patient relationship that focuses on quality patient care and open lines of communication. The parties to this agreement shall agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the physician /patient relationship, the patient agrees to submit in writing to the MaternOhio Mediation Program, any dispute, controversy or disagreement arising out of or relating to the physician /patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to the MaternOhio Mediation Program, the parties shall use negotiation in an attempt to reach a voluntary resolution of their differences.

2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter shall be submitted to mediation in accordance with the MaternOhio Mediation Program Rules of Procedure.

Mediation is a process in which a neutral third party helps the doctor and the patient discuss the issues that have arisen between them with the ultimate goal of resolving any problems. Either party is entitled to seek legal representation at any time, but MaternOhio wishes to provide the patient with this opportunity to settle any problems that may have arisen without the need to incur additional costs and fees.

These Mediation Rules of Procedure provide in part that:

- The patient is not required to reach a resolution in mediation.
- The mediator (or co-mediators) will be a neutral third party who is trained in mediation.
- All mediation sessions are considered confidential as defined in Ohio Revised Code 2317.023.
- The costs of the mediation will be paid by MaternOhio.
- The date, time and place of any mediation session shall be scheduled by the mediator in consultation with the parties.
- The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
- Any agreements reached by the parties shall be in writing and signed by both parties.
- Parties considering mediation should remember by signing this agreement they agree to make a good faith effort at mediation before pursuing litigation. Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

It is the goal of MaternOhio Management, Inc. that all physicians and patients engage in a cooperative approach to ensure quality healthcare and that any conflicts that may arise between them will be resolved in the same cooperative style through mediation.

____________________________ ____________________________

Patient Date Witness Date