NWO CENTER FOR PELVIC REHAB & WELLNESS
Karen Liberi, MS, MPT, WCS ~ Peg Zientek, PTA
Amy Schnorberger, MS, PT, CNDT ~ Manda Nofziger, PT
28442 E River Road, #103 – Perrysburg, OH 43551
Phone: 419 893 7134, Option #5 – Fax: 419 873 6812

NWO CENTER FOR UROGYNECOLOGY
Andrew Croak, DO ~ Tracey Begley, WHNP
Nancy Pahl, WHNP-BC
28442 E. River Road, #111 – Perrysburg, Ohio 43551
Phone: 419 893 7134 Fax: 419 893 6942

Dear _____,

You have an appointment scheduled with NWO Center for Pelvic Rehab & Wellness on:

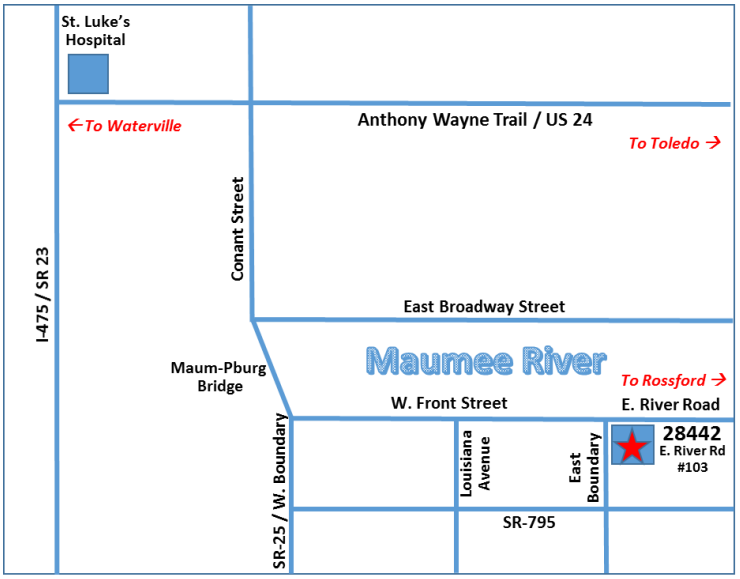
_____ at _____.

Welcome to our office. We are glad you chose us for all your personal care needs. Our office is located at ***28442 E. River Road, #103 ~ Perrysburg, Ohio 43551.*** *We can be reached at* ***419 893 7134, Option 5*** *if you have questions*. See maps below for office location and parking lot access.

Please fax, e-mail or mail all completed paperwork PRIOR to your visit.
FAX: 419 873 6812 E-MAIL: pftstaff@nwourogyn.com

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

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



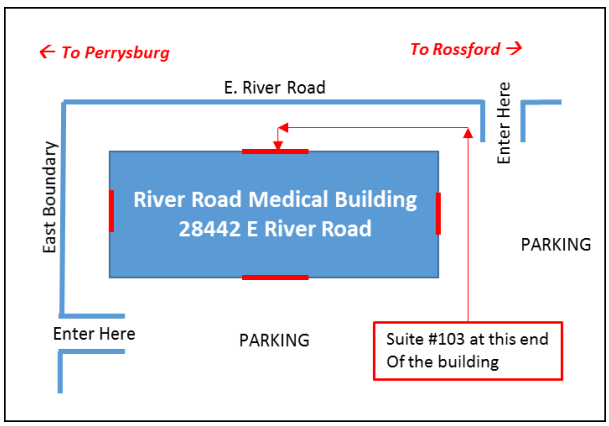
Directions to the Office:

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

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

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

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



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PATIENT INFORMATION

Name:	SS#:	NCDS#:
Address:	Email:	
City/State/Zip:	DOB:	Sex:
Home Phone:	Marital Status:	
Cell Phone:	Emergency Contact:	
Work Phone:	Emergency Phone:	
Primary Care Physician:	Emergency Relationship:	
Language:		
Race: (circle one) White American Indian Asian Black/African American Unknown Declined		
Ethnicity: (circle one) Non-Hispanic or Latino Hispanic or Latino Declined		

INSURANCE INFORMATION

Primary Ins:	Secondary Ins:
ID #:	ID #:
Group #:	Group #:
Co-Pay:	Co-Pay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

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

Health Information Privacy Act (HIPAA) - Check all that apply

Home ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Cell ☐ OK to leave message w/ detailed information OR ☐ Leave return phone # only
Text ☐ Appointment Reminder/General message to call our office
Email ☐ Appointment Reminder/General message to call our office
Home Address: ☐ Ok to mail to my home address

☐ I permit the Practice to discuss my personal health information (PHI) with, and to disclose to, the following individuals:

Name: _____ Phone: _____
Relationship to Patient: _____
Name: _____ Phone: _____
Relationship to Patient: _____

I verify that all of the above demographic, insurance, and HIPAA information is true and correct:

_____ _____
Patient Signature Date

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

NWO CENTER FOR
PELVIC REHAB & WELLNESS

NWO CENTER FOR
UROGYNECOLOGY & WOMEN'S HEALTH

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

Who referred you to our office? _____Primary Care Provider _____

What is the reason for your visit today? _____

Personal Medical History (check all that apply)

☐ Testicular cancer	☐ Seizures/Epilepsy	☐ Osteoporosis/osteopenia	☐ Birth defect(s)
☐ Prostate cancer	☐ Multiple sclerosis	☐ Bone fracture	☐ Exposure to DES
☐ Colon cancer	☐ Anxiety	☐ Vitamin D deficiency	☐ Digestive problems
☐ Other Cancer: _____	☐ Depression	☐ Arthritis	☐ Colon problems
☐ Diabetes	☐ Heart attack	☐ Joint replacement	☐ Bladder/Kidney disease
☐ High blood pressure	☐ Stroke	☐ Lung disease _____	☐ Urinary infections
☐ High cholesterol	☐ Blood clots: _____	☐ Skin problem _____	☐ Glaucoma
☐ Heart disease	☐Heart valve problems	☐ Anemia	☐
☐ Tension headaches	☐ Thyroid disease	☐ Jaundice/Hepatitis	☐
☐ Migraine headaches	☐ Parkinson's disease	☐ HIV/AIDS	☐

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

_____

_____

Sexual History

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

Do you have to take antibiotics before dental work or other procedures? ☐ Yes ☐ No If yes,_____(Reason)

Drug/Food/Other Allergies (Please give reaction, i.e. hives)

☐ **N/A** (please check box if this does not apply)

_____

_____

Patient Name: _____

Surgical History

Date	Procedure	Reason for Surgery
☐ **N/A** (please check box if this does not apply)		

Medications

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

☐ **N/A** (please check box if this does not apply)					
Name of medication	**Dose**	**How often taken**	**Name of medication**	**Dose**	**How often taken**

Local Pharmacy

_____

Name Address Phone #

Mail Order Pharmacy

_____

Name Address Phone #

Family History

Diagnosis	Relationship	Age @ Diag	Diagnosis	Relationship	Age @ Diag
Testicular cancer		1	Heart Disease		
Prostate cancer			Stroke		
Colon cancer			Heart attack		
Other cancer: _____			High cholesterol		
Osteoporosis			Genetic disease		
Diabetes			Anesthesia complication		
Hypertension			Clotting disorder		
Other: _____			Other: _____		

Social History

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

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

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

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

Do you consume alcohol? ☐ Yes ☐ No How many alcoholic beverages/week? _____

Do you use illicit drugs? ☐ Yes ☐ No List: _____

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

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

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

Preventative History

When was your last prostate check? _____ Facility: _____

Last Colonoscopy/sigmoidoscopy: _____ Facility: _____

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

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

Have you had any prior physical/occupational/speech or chiropractic treatments this year? ☐ Yes ☐ No How many _____

OFFICE POLICIES SIGNATURE PAGE

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

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

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

BILLING & INSURANCE:

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

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

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

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

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

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

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

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

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

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

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

_____ Date:_____

Patient Signature

_____

Printed Name

Rev 05/01/2018