



## NWO CENTER FOR PELVIC REHAB & WELLNESS

Karen Liberi, MS, MPT, WCS ~ Amy Schnorberger, MS, PT, CNDT ~ Peg Zientek, PTA

28442 E River Road, #103 – Perrysburg, OH 43551

Phone: 419 893 7134, Option #5 – Fax: 419 873 6812

*In association w/ NWO CENTER FOR UROGYNECOLOGY - Andrew Croak, DO ~ Tracey Begley, WHNP ~ Jill Nichols, 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](mailto: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.

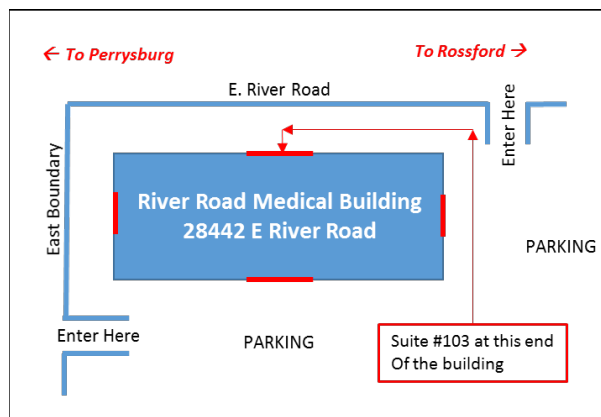
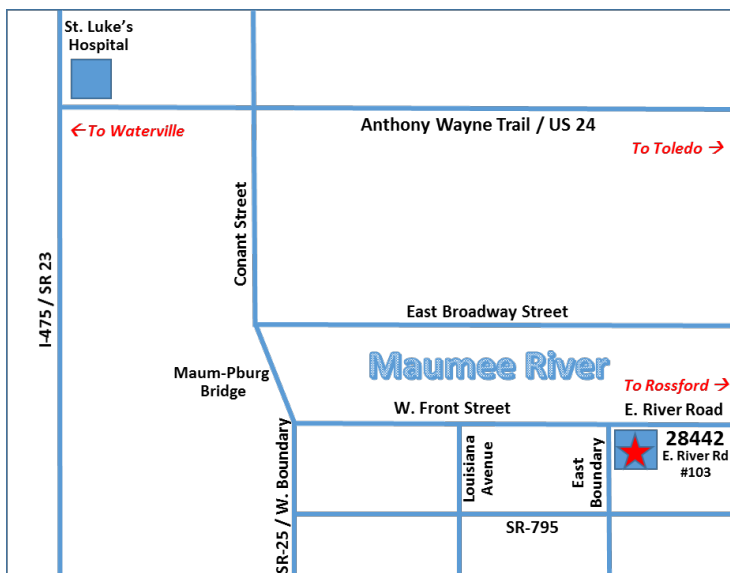
### Directions to the Office:

**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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P: 419 893 7134, Option 5 F: 419 873 6812 W: www.nwourogyn.com

### 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  
(Typed name confirms electronic signature)

\_\_\_\_\_  
Date

If signed by patient's authorized representative, describe the representative's authority: \_\_\_\_\_  
(Typed name confirms electronic signature)



**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? \_\_\_\_\_

**Menstrual History**

Age at first menstrual period \_\_\_\_\_ First day of your last period \_\_\_\_\_ If applicable: How many days do your periods last? \_\_\_\_\_

How many pads/tampons do you typically use in a 24 hours? \_\_\_\_\_ pads \_\_\_\_\_ tampons

	Yes	No	N/A
Are your menstrual cycles regular (every 21-35 days)?			
Do you have bleeding or spotting between periods?			
Do you have pain with your periods?			
Do you have pain in your lower abdomen or pelvis other than painful periods?			
If you are menopausal, have you experienced any further vaginal bleeding?			

**In order to have complete medical diagnoses and treatment, please answer the following:**

Gender Identity: Male Female Transgender: MTF FTM

If applicable, preference of Gender Pronoun to be used: \_\_\_\_\_

**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?			
Are you using birth control? If yes, what method? _____			
Have you ever had a sexually transmitted infection? If yes, please explain: _____			

**Pregnancy History**

Total number of pregnancies: \_\_\_\_\_ Vaginal Deliveries: \_\_\_\_\_ C-Sections: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Ectopic pregnancies: \_\_\_\_\_ Abortions: \_\_\_\_\_

**Have you recently had any of the following symptoms (within the last month)?**

Yes No			Yes No			Yes No		
Vaginal discharge			Burning or pain with urination			Pressure or bulge at the opening of the vagina		
Vulvar itching or irritation			Leakage of urine					
Breast pain			Frequent urination			Incontinence of stool		
Breast lump/mass			Difficulty emptying your bladder			Blood in your stool		
Hot flashes and/or night sweats			Urinary tract infections			Significant/chronic diarrhea		
Weight gain/loss of 10 lbs			Chronic coughing			Significant/chronic constipation		

Patient Name \_\_\_\_\_

### **Personal Medical History (check all that apply)**

Breast cancer	Tension headaches	Thyroid disease	Jaundice/Hepatitis
Ovarian cancer	Migraine headaches	Parkinson's disease	HIV/AIDS
Uterine cancer	Seizures/Epilepsy	Osteoporosis/osteopenia	Birth defects
Colon cancer	Multiple sclerosis	Bone fracture	Exposure to DES
Other cancer: _____	Anxiety	Vitamin D deficiency	Digestive problems
Abnormal pap test	Depression	Arthritis	Breast problems
Diabetes	Heart attack	Joint replacement	Colon problems
High blood pressure	Stroke	Lung disease	Bladder/kidney disease
High cholesterol	Blood clots	Skin problems	Urinary infections
Heart disease	Heart valve problem	Anemia	Glaucoma

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

**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)

## 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)

[illegible]

Patient Name \_\_\_\_\_

### Pharmacy Information

	Name	Street Address	City, State Zip	Phone
LOCAL				
MAIL ORDER				

### Family History

	Father	Mother	Brothers	Sisters	Sons	Daughters
How Many?	1	1				
Deceased? Yes/no	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Diagnosis:						
Diabetes						
Cardiac						
Breast Cancer						
Cervical Cancer						
Uterine Cancer						
Colon Cancer						
Bleeding Disorders						
Osteoporosis						

### 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

Last Pap Smear/Pelvic Exam: \_\_\_\_\_ Facility: \_\_\_\_\_

Have you ever had an abnormal pap smear?    Yes    No    Treatment if applicable: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_ Facility: \_\_\_\_\_

Have you ever had an abnormal mammogram?    Yes    No    Treatment if applicable: \_\_\_\_\_

Last Bone Density Test (DEXA scan): \_\_\_\_\_ Facility: \_\_\_\_\_

Last Colonoscopy/sigmoidoscopy: \_\_\_\_\_ Facility: \_\_\_\_\_

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

Dates of Last:    Flu: \_\_\_\_\_ Tdap: \_\_\_\_\_ Pneumonia: \_\_\_\_\_ Shingles: \_\_\_\_\_ Gardasil (HPV): \_\_\_\_\_ Covid-19: \_\_\_\_\_

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

## OFFICE POLICIES SIGNATURE PAGE

Thank you for choosing the NWO Center for Urogynecology and Women's Health as your health care provider. We take our responsibility seriously towards providing compassionate affordable care tailored to an individual's specific needs.

1. We give the power of choice, saving patients from unnecessary expense
2. We provide pre-authorization prior to testing and treatment to prevent surprise billing
3. We humanistically only have charged partial deductibles to schedule treatments in the past
4. We are part of an ACO saving our patients in excess of \$7 million a year
5. We write off over 70% of what we bill out, so patients get affordable quality care

HIPAA 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.

For 2023 and beyond, a few disturbing trends are occurring:

1. More patients than ever before have insurance with large deductibles. Although most patients pay their deductible responsibilities in a timely manner, an increasing number of patients, despite pre-procedural assurances, are simply not paying their post-procedural balances.
2. Several insurance companies have begun the egregious practice of initially approving a surgery and then retroactively denying the surgery after it is completed. We are monitoring this trend with the Ohio State Medical Association.

Thus we are asking our patients to kindly understand or refresh themselves with the following billing & insurance policy points that are in effect:

### **BILLING & INSURANCE:**

- Plan Participation: ***It is the patient's responsibility to know and understand their insurance plan.***
- Prior Authorization: The courtesy of prior authorization may only be able to provide best cost estimates based on deductibles. A final balance may vary slightly from initial estimates.
- No Insurance: ***If you do not have insurance, payment in full is expected at the time of service.***
- Deductibles: If insurance deductible has not been met, it will be used to cover treatment expense in accordance with insurance. ***Any unmet deductible will be calculated and expected to be paid in full at the time of service for procedures/surgery.***
- Pre-Surgical Payments: Similar to deductible above, 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.***
- 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.
- Secondary Insurers: A patient is responsible for any balances after 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.
- Non-covered Services: It will be patient's responsibility to contact their insurance company if a service is not covered.
- Request for Prescription without a Visit: A \$25 fee will be charged for prescription request without being seen in the office (i.e., after hours or weekend call). This would not apply if patient has been seen and requires a medication change.
- Account 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, you may receive a collection letter and be considered for further collection activity.

**ENDING 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 advance, a \$50 fee may be charged to your account to be paid in full prior to any future services being rendered. Repeated missed or cancelled appointments may result in termination of services with this office. If you run late for your appointment (10 minutes more), staff reserve the right to reschedule the appointment. Keep in mind, it costs minimally \$250 in time, supplies, staffing, for the office to prepare for your visit.

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

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

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Patient Signature  
*(Typed name confirms electronic signature)*

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Date

Revised 02/01/2023