GENERATIONS
WOMEN'S HEALTH

Danielle Kiko, M.D., FACOG
Board Certified OB/GYN

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Board Certified OB/GYN

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128 Wertz Ave. NW • Suite B
Canton, Ohio 44708-4196
Phone: 330-956-5300 • Fax: 330-956-5318

Date: _____

Last Name:	First Name:	M.I.	Maiden Name:	Date of Birth:

Mailing Address:	City and State:	Zip Code:

Marital Status (Circle): Single Married Divorced Separated Widowed	Race (Circle): American Indian or Alaska Native Asian Black or African American Caucasian

Social Security Number:	Driver's License #:	Religious Denomination:	Language:	Ethnicity: ___Hispanic/Latino ___Not Hispanic or latino

Cell Phone:	
Home Phone:	
Work Phone:	
Email Address:	
Employer:	
Employer Address:	
Spouse's Name:	
Work Phone:	
Cell Phone:	
Employer:	
Emergency Contact Name:	
Phone Number:	
Referred by:	
Primary Care Physician	
Preferred Pharmacy	

By signing below, you acknowledge receipt or have read our financial policy on our website under "New Patient FYI Forms", and agree to the terms

_____ _____

Signature Date:

Primary Insurance Information:	
Policy Holder	
Date of Birth:	
Social Security #	
Insurance Provider	
Effective Date:	
Expiration Date:	
ID #	
Group Name or #	
Co-Pay Amount	

Secondary Insurance Information:	
Policy Holder	
Date of Birth:	
Social Security #	
Insurance Provider	
Effective Date:	
Expiration Date:	
ID #	
Group Name or #	
Co-Pay Amount	

Intake History Form

Name: _____ Date of Birth: _____

Allergies: 1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____
5. _____ Reaction: _____

Past Medical History: (Circle all that apply)

Glaucoma Stroke Hypothyroid (underactive) Hyperthyroid (overactive) Asthma Anemia
Blood Clots Heart Attack Heart Murmur High Blood Pressure High Cholesterol Diabetes
Seizures/Epilepsy Irritable Bowel Crohn's Disease Diverticulitis Stomach Ulcers Hepatitis HIV
Kidney Infections/Stones HPV Other: _____

_____

Past Surgical Hysterectomy: (Circle all that apply)

Gallbladder Appendix Umbilical Hernia Incisional Hernia Ablation Hysterectomy (Abdominal)
Hysterectomy (Vaginal) Hysterectomy (Laparoscopic) Right tube/ovary out Left Tube/ovary removed
Both Tubes/ovaries out Knee Hip Mastectomy Breast Lumpectomy Tonsils Tonsils & Adenoids
Wisdom Teeth Other: _____

Medications:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Social History:

Smoke No Yes: Current or Former _____packs per day
Alcohol No Yes: Social Occasional Weekly Daily _____
Drugs No Yes: _____
Married Single Widowed Divorce

Name: _____ Date of Birth: _____

Family History: (those not on Hereditary Cancer Questionaire)

Blood Clots: _____

Heart Disease: _____

Diabetes: _____

High Blood Pressure: _____

Osteoporosis: _____

Strokes: _____

Bleeding or Clotting Disorders: _____

High Fever During Anesthesia: _____

Please circle any symptoms you currently have:

Weight Loss Weight Gain Fever Excessive Fatigue Double Vision Seeing Spots Ear Aches Sore throat
Diarrhea Constipation Nausea/Vomiting Bloody Stools Shortness of Breath Difficulty Breathing
Chest Pain Heart Palpitations Swelling of Legs Wheezing Cough Swollen Lymph Nodes Back Pain
Muscle Weakness Dizziness Numbness Depression Anxiety Abnormal/Changing Moles Hot Flashes
Increased Thirst Increased Urination Incontinence of Urine or Stool Pain with Urinating Urinary Urgency
Waking to Urinate Incomplete Bladder Emptying Vaginal Itching Vaginal Burning Vaginal Dryness
Pain with Intercourse Vaginal Lesions Pain with Menses Spotting Between Menses

Menstrual History:

Age of First Menses: _____ Age at Menopause: _____

How far apart are your periods? (in days): _____ How long do your periods last?: _____

How long, collectively, have you used birth control in your life: _____ less than 5 years _____ more than 5years

When is the last time you used birth control? _____currently ____less than 5 years ago ____more than 5 years ago

Total # Pregnancies: _____ # Full term: _____ # Preterm: _____ # Living Children: _____

Miscarriages: _____ # Abortions: _____ # Ectopics: _____ # Multiple Births: _____

Year	Weeks Pregnant	Delivery Type	Complications	Weight	Sex

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-----	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME GASTROINTESTINAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more gastrointestinal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

RELEASE of INFORMATION

I HEREBY AUTHORIZE DANIELLE KIKO, M.D., LLC TO DISCLOSE ALL OR ANY PART OF MY MEDICAL INFORMATION TO:

1. Any person or entity that may be liable to Danielle Kiko, M.D., LLC for all or part of the charges for my medical care, including but not limited to: Hospital or Medical Service Companies, Insurance Companies, Medical Claims Payers, Medicaid and Medicare.
2. Any person or entity that is involved in my medical treatment, and communication among many health professionals who contribute to my care.
3. The legal Counsel of Danielle Kiko, M.D., LLC, in any matter to which such information is relevant and necessary.
4. Collection agencies retained by Danielle Kiko, M.D., LLC to obtain payment of my accounts.
5. Persons or entities performing audits, or analyzing patient medical information for peer review, quality of care, financial or compliance purposes. (A means by which a third-party payer can verify that services billed were actually provided).

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original. I hereby authorize Danielle Kiko, M.D., LLC to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made **direct** to Danielle Kiko, M.D., LLC, and I certify the information I reported in regards to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time in writing. I understand that I am financially responsible for any balances not covered by insurance.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Danielle Kiko, M.D., LLC operations. The notice of Privacy Practices also describes my rights and Danielle Kiko, M.D., LLC duties with respect to my protected health information. The Notice of Privacy Practices is posted in our waiting room.

Danielle Kiko, M.D., LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or asking for one at time of appointment.

_____

Signature of Patient or Personal Representative Date

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 Revises Code 2317.023.
- The cost 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

Generations Women's Health

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

330 956-5300

We will not retaliate against you for filing a complaint.

Effective Date 04-2017 Publication Date _____

Patient Instructions for Form 7.31

Limited Patient Authorization for Disclosure of Protected Health Information

This form will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization limits us to disclose only the information that you designate, and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information (i.e., our practice).

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure. If you would like your PHI emailed to the recipient, please provide the email address that you would like us to use, and review the note on the form regarding Secure Communication.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on completion of this authorization form.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: Generations Women's Health

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone/Fax: _____ / _____

Email *: _____

* **Secure Communication** - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
patient or authorized representative signature — date

_____ _____
patient or authorized representative signature — date

_____ _____
patient or authorized representative signature — date

_____ _____
patient or authorized representative signature — date

You have the right to receive a copy of signed authorizations upon request.