CENTER FOR ENDOMETRIOSIS CARE PROSPECTIVE PATIENT INFORMATION PACKET *Version 8.2023*

PLEASE BE ADVISED THESE FORMS MUST BE COMPLETED IN ADVANCE OF YOUR REVIEW. MANY THANKS FOR YOUR KIND ASSISTANCE. PLEASE FEEL FREE TO ATTACH ADDITIONAL SHEETS IF NECESSARY.

Today's Date:_____

Full legal name, including middle initial (if any):_____

Preferred name, if different from above:_____

Preferred gender pronoun:_____

Who may we thank for your referral to our Center?_____

What is your primary reason for seeking consultation for surgery (circle only one)? PAIN INFERTILITY

Date of Birth & Age:_____

Complete Mailing Address:_____

E-mail address:_____

Phone Number:_____

Preferred Method of Appointment Confirmation:
- ☐ Email
- ☐ Phone

Occupation:_____

Name of Employer if Any:_____

If Student, School Name:_____
Full Time / Part Time (circle one)

Relationship/Marital status: Single / Married / Partnered/living together / Divorced / Widowed / Other

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino
Race (circle one): American Indian or Alaska Native / Asian / Native Hawaiian or Other Pacific Islander / Black or African American / White / More than one Race / Other

Do you have a history of abuse?* Check all that apply:
- ☐ Emotionally
- ☐ Physically
- ☐ Sexually
- ☐ I was NOT abused

***Why we ask**: in accordance with the ACOG Committee Opinion (#498, August 2011, reaffirmed 2019), a compassionate understanding of the magnitude and effects of abuse, along with knowledge about screening and intervention methods, can help us offer appropriate care and support to our patients with such histories. **This information is collected only to help us ensure your absolute comfort during your care with the CEC.** By being aware of your needs, we can work to avoid triggers and help tailor our services and physical examinations to help make you feel as safe as possible in our care. Disclosure is completely voluntary; you have absolute control over this information and your willingness to share it with us. Please know that all information shared with the Center for Endometriosis Care is strictly confidential.*

Sex assigned at birth on your original birth certificate: Male / Female
Do you self-identify as: Female / Gender Diverse / Intersex / Other
Do you self-identify as: Straight or Heterosexual / Homosexual / Bisexual / Other / Don't Know

***Why we ask**: in an effort to ensure inclusivity and in accordance with policy focus recommendations issued by the National Fenway Health Institute and the sexual identity addition to the National Health Interview Surveys conducted by the U.S. Department of Health & Human Services, we provide our constituency with the opportunity to self-identify as to their sexual orientation and gender identity. Gathering this data in our clinical setting is a crucial step towards the national effort currently underway to reduce health disparities and promote health equity for all individuals and allows us to tailor your care to your needs. Disclosure is completely voluntary; you have absolute control over this information and your willingness to share it with us. Please know that all information shared with the Center for Endometriosis Care is strictly confidential. Additionally, sections 1411(g), 1411(c)(2), and 1414(a)(1) of the 2010 Patient Protection & Affordable Care Act provide the strictest privacy and security protections for this information.*

In accordance with the clinical guidance issued by the American Medical Association and the Centers for Disease Control, we now request all patients complete the following exposure risk assessment information:

Do you currently have signs/symptoms of fever, fatigue, sore throat, cough, body aches, diarrhea, nausea, or a loss of taste or smell?
YES NO

Even if you don't currently have any of the above symptoms, have you or anyone in your household experienced any of these symptoms in the last 14 days?
YES NO

Have you or anyone in your household been tested for COVID-19 and are awaiting results?
YES NO

Have you or anyone in your household tested positive for COVID-19 in the past 90 days?
YES NO

Have you or anyone in your household been in direct contact with someone who has tested positive for COVID-19 in the past 90 days?
YES NO

Have you or anyone in your household traveled outside the United States by air or cruise ship in the past 14 days? YES NO

Have you received a COVID-19 vaccination?
YES NO
If yes, please list type (e.g. Moderna) and date last/final dose was received

Notes:
1.) Fever may be subjective or confirmed.
2.) "Close contact" is defined as a) being within approximately 6 feet (2 meters) of a 2019-nCoV case for a prolonged period of time; close contact can occur while caring for, living with, visiting or sharing a health care waiting area or room with a 2019-nCoV case; – or – b) having direct contact with infectious secretions of a 2019-nCoV case (e.g. being coughed on).

Please be sure to visit https://centerforendo.com/covid19-updates for the latest COVID-related requirements and protocols for all surgical and in-office CEC patients. Thank you.

Parent / Guardian / Spouse / Partner Information Form

Full name of Partner/Guardian/Spouse/Parent: _____

Their date of Birth/Age: _____

Their Complete Mailing Address: _____

Their E-mail address(es): _____

Their Phone Number(s):_____

Their Occupation:_____

Their Employer:_____

Their Employer Telephone #:_____

Please initial here to indicate we have your permission to speak with the above-named individual in cases of emergency: _____

Emergency Contact Information

Name of Emergency Contact #1:_____

Relationship:_____

Phone #:_____

Name of Emergency Contact #2:_____

Relationship:_____

Phone #:_____

Please initial here to indicate we have your permission to speak with the above-named individuals in cases of emergency: _____

Primary Insurance Information (if applicable)

Insured's Full Name including Middle Initial:_____

Insured's Date of Birth: _____

Relationship to Patient:_____

Name of Insurance Company:_____

Complete Mailing Address: _____

Telephone #:_____

Identification #:_____Group #:_____

Secondary Insurance Information (if applicable)

Insured's Full Name including Middle Initial:_____

Insured's Date of Birth: _____

Relationship to Patient:_____

Name of Insurance Company:_____

Complete Mailing Address: _____

Telephone #:_____

Identification #:_____Group #:_____

Are there any other health insurance benefit plans (circle one)? Yes No

I certify that the above information is correct:

_____ _____

Patient/Proxy Printed Name *Signature*

MEDICATIONS, SUPPLEMENTS & ALLERGIES

Please list ALL names of your medications, including over the counter or prescribed, doses, and how often you take them. Please be thorough. Add additional sheets if necessary.

Medication Name	*Dose*	*How often taken*	*Reason for taking*

Please list ALL names of your supplements, including over the counter or prescribed, doses, and how often you take them. Please be thorough. Add additional sheets if necessary.

Supplement Name	*Dose*	*How often taken*	*Reason for taking*

ALLERGIES: Please list all medications, supplements and substances to which you are allergic (e.g. Latex, Vicodin®) and the kinds of reactions you get:

Allergen Name	*Dose*	*How often taken*	*Reason for taking*

PHARMACY NAME & CONTACT INFORMATION

Pharmacy Name
Phone #
Fax #
Mailing Address

FAMILY HISTORY: Please fill in the chart below and check the appropriate boxes

Relationship	Status (Alive/Deceased)	Diabetes	Breast Cancer	Ovarian Cancer	Colon Cancer	Osteoporosis	Heart Disease	Hypertension	Elevated Lipids	Deep Vein Thrombosis	Pulmonary Embolism	Depression	Endometriosis	Interstitial Cyst	Vulvudynia	Prostate Cancer	Uterine Cancer	Stroke
Paternal Grandfather																		
Paternal Grandmother																		
Maternal Grandfather																		
Maternal Grandmother																		
Father																		
Mother																		
Brother																		
Sister																		
Child																		

Other? Please list here.

SOCIAL HISTORY: Tell us about yourself and your habits.

TOBACCO USE		**ALCOHOL USE**	
	I currently smoke_pack/day for__years		I currently use alcohol, and drink about drinks a week
	I have never smoked		I do not drink alcohol
	I used to smoke, but quitin _____		
	I have only been exposed to passive smoke (others smoke, but not me)		
	I use chewing tobacco		

STREET DRUG USE			
	Yes, I use street drugs. List kinds:		No, I do not use street drugs.

Some of the following information has been adapted in part from the American Board of Internal Medicine's Choosing Wisely® initiative, the Centers for Disease Control and My Opioid Manager© by the Toronto Rehabilitation Institute, University Health Network.

Understanding Opioids

Your doctor may offer you opioids to help manage your pain. These are medications derived from opium or synthesized in laboratories, and are the most potent pain relievers available today. There are many different types of opioids available, including codeine, oxycodone, morphine, hydromorphone and fentanyl. Opioids are utilized to reduce pain, so you can improve your ability to be active. Short-term use of these medicines may help, but there is no evidence that they work well over time. Opioids do not cure chronic pain; the goal is to manage pain enough to be able to take part in the activities that improve pain and life.

"Narcotic" is a broader category of drugs that includes prescription opioids, but also includes some street drugs such as heroin or cocaine. All opioids are narcotics, but not all narcotics are opioids. There are many different types of opioids available on the market in various strengths and forms, both 'weak' and 'strong.' Weak opioids include codeine, hydrocodone (Vicodin® and generic) and tramadol. The strength of these medications is limited because in higher doses they create too many adverse effects. Therefore, they are used to treat mild pain. Strong opioids include morphine, oxycodone (OxyContin®, Percocet®, and generic), hydromorphone (Dilaudid® and generic), fentanyl, methadone, buprenorphine, tapentadol and oxymorphone. These medications are usually used to treat moderate to severe pain.

Opioids have serious side effects and risks; therefore, it is our goal to appropriately manage your care accordingly. Over time, the body gets used to opioids and they stop working as well. To get the same relief, you would need to take higher doses, which can cause serious side effects, including but not limited to –

- Adverse events, such as sleepiness, confusion or dizziness
- Medical complications, such as sleep apnea, lowered sex hormones and increased pain caused by the opioid (opioid induced hyperalgesia)
- Breathing problems, which can be deadly
- Dry skin
- Nausea/Vomiting
- Itching
- Constipation
- Not being able to urinate enough
- Confusion and mental disturbance
- Misuse and abuse, which may lead to addiction; up to one in four people who take opioids long-term become addicted
- Overdose, which may lead to death

Other pain treatments may work better and have fewer risks:

- Over-the-counter medication
- Injections, such as steroids
- Other prescription drugs (ask about risks and side effects):
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Anti-seizure drugs

- Non-drug treatments:
  - Exercise
  - Physical therapy
  - Spinal manipulation
  - Massage therapy
  - Acupuncture

PATIENT FULL NAME:_____ **DATE OF BIRTH:**_____

Please respond accordingly. All answers are confidential and never shared.

Do you have a family history of substance abuse? YES NO
If yes, please circle all that apply: alcohol, prescription drugs, illegal drugs, other (describe)

Do you have a personal history of substance abuse? YES NO
If yes, please circle all that apply: alcohol, prescription drugs, illegal drugs, other (describe)

Have you been diagnosed with a Mental Health condition? YES NO
If yes, please circle all that apply: depression, obsessive compulsive disorder, anxiety, post-traumatic stress syndrome/disorder, bipolar, schizophrenia, panic attacks, other (describe)

Do you currently take, or have you taken in the past 12 months, any narcotic/opioid analgesics? YES NO
If yes, please complete the following:

NAME OF OPIOID ANALGESIC YOU CURRENTLY TAKE / HAVE TAKEN IN THE PAST 12 MONTHS	DOSAGE PRESCRIBED	NUMBER OF TIMES TAKEN DAILY	REASON(S) PRESCRIBED & PRESCRIBING PHYSICIAN NAME	START DATE	END DATE IF APPLICABLE	WHY DID YOU STOP TAKING THE PRESCRIPTION? E.G., PRESCRIPTION ENDED, NO LONGER NEEDED, SIDE EFFECTS, ETC.	PAIN LEVEL ON A SCALE OF 1-10 WHILE TAKING THE MEDICATION

Do you currently take, or have you taken in the past 12 months, any NON-narcotic/opioid analgesics? YES NO
If yes, please complete the following:

NAME OF NON-OPIOID ANALGESIC YOU CURRENT TAKE / HAVE TAKEN IN THE PAST 12 MONTHS	DOSAGE PRESCRIBED	NUMBER OF TIMES TAKEN DAILY	REASON(S) TAKEN	START DATE	END DATE IF APPLICABLE	WHY DID YOU STOP TAKING THE MEDICATION? E.G., NO LONGER NEEDED, SIDE EFFECTS, ETC.	PAIN LEVEL ON A SCALE OF 1-10 WHILE TAKING THE MEDICATION

Symptoms/Experiences

PLEASE COMPLETE EACH QUESTION. IF A QUESTION DOES NOT PERTAIN TO YOU, PLEASE MARK 'N/A' AS YOUR ANSWER.
PLEASE BE AS SPECIFIC AS POSSIBLE. THANK YOU.

Are you aware of any additions or corrections to the medical information we have collected in your records? Please note.

Please rate the quality of life as you are experiencing it **now**: □ Awful □ Poor □ Fair □ Good □ Terrific

Rate the degree of symptoms. Choose one box for each symptom. "Crippling pain" is so bad it keeps you from performing daily tasks/severely limits activity at least one day per month.

Height_____Weight_____Date Symptoms Began _____

____Dysmenorrhea (painful periods) □ Does not apply □ slight □ moderate □ severe □ crippling

____Deep dyspareunia □ Does not apply □ slight □ moderate □ severe □ crippling

____Pelvic pain with exercise □ Does not apply □ slight □ moderate □ severe □ crippling

____Painful bowel movement □ Does not apply □ slight □ moderate □ severe □ crippling

____Constipation □ Does not apply □ slight □ moderate □ severe □ crippling

____Bladder pain □ Does not apply □ slight □ moderate □ severe □ crippling

____Intestinal cramping □ Does not apply □ slight □ moderate □ severe □ crippling

____Tenderness on pelvic exam □ Does not apply □ slight □ moderate □ severe □ crippling

____Abdominal pain □ Does not apply □ slight □ moderate □ severe □ crippling

____Leg ache □ Does not apply □ slight □ moderate □ severe □ crippling

____Backache □ Does not apply □ slight □ moderate □ severe □ crippling

____Pelvic pain □ Does not apply □ slight □ moderate □ severe □ crippling

____Nausea w/menses □ Does not apply □ slight □ moderate □ severe □ crippling

____Diarrhea □ Does not apply □ slight □ moderate □ severe □ crippling

____Diarrhea w/menses □ Does not apply □ slight □ moderate □ severe □ crippling

____Vomiting w/menses □ Does not apply □ slight □ moderate □ severe □ crippling

____Fatigue □ Does not apply □ slight □ moderate □ severe □ crippling

____Ovulation pain □ Does not apply □ slight □ moderate □ severe □ crippling

____Chest pain/coughing up blood anytime during the cycle (with or without menses) □ Does not apply □ slight □ moderate □ severe □ crippling

____Other _____

____Using analgesics?

Have you ever had unprotected intercourse for six months or longer? □ yes □ no

Have you ever tried to conceive? □ Yes, for_____months and_____years □ No

Have you ever been pregnant? □ yes □ no

If yes, number of pregnancies:_____Outcomes: □ Live births □ Miscarriages □ Stillbirths □ Abortions

Do you menstruate? □ YES □ NO	If yes, at what age did you begin to have periods? What is the date of the first day of your last period?
If you do not menstruate, explain why (hysterectomy, suppression, menopause, etc.):	
Are you doubling over in pain, or lying down in pain, during your period? □ YES □ NO	
Have you had to miss activities, school or work due to pelvic pain? □ YES □ NO	
Have you been to the Emergency Room for pelvic pain, but have not been given a specific diagnosis? □ YES □ NO	
Have you had to take narcotics for pelvic pain? □ YES □ NO	
Have you ever been on hormonal suppression (examples include birth control pills, injections, GnRH, Mirena IUD) for pain with menstrual cramps? □ YES □ NO	If yes, at what age did you first use suppressive hormones? If yes, for how many months total in your lifetime did you take suppressive medications? If yes, what were/are the reasons? Pain Other (describe) If yes, please list all suppressive hormone therapies as best you can recall:
Are you currently on any of the medications listed above? □ YES □ NO	If yes, please list name(s):
If NOT currently on hormonal suppression, when were you last on it? Date:	
Do you have a family history of endometriosis? □ YES □ NO	If yes, list relationship (e.g., mother, sister, cousin, etc.)
Have you had prior surgery for pelvic pain or for infertility? □ YES □ NO	If yes, at what age was your first surgery? If yes, how many surgeries have you had for endometriosis/pelvic pain/infertility in all? If yes, list the approximate date (month/year) of your most recent surgery
Was endometriosis diagnosed surgically via biopsy confirmation in any of the surgeries? □ YES □ NO	If yes, what was the most severe stage of endometriosis found? (circle one) I II III IV not known
Have you ever had treatment for suspected/confirmed endometriosis (either clinically or surgically diagnosed)? □ YES □ NO	If yes, please circle all that apply: ablation vaporization cauterization excision medical suppression other (explain)

When was your last pap smear?	Approximate Date
Have you ever had an abnormal pap smear?	□ YES □ NO If yes, what were the findings?
At what age did you begin to have pelvic pain symptoms?	Age
Are you now or have you ever been sexually active?	□ YES □ NO
Have you ever had a sexually transmitted infection (STI)?	□ YES □ NO If yes, what was the diagnosis?
When was your last mammogram?	Approximate Date
When was your last colonoscopy?	Approximate Date

PATIENT ASSESSMENT QUESTIONNAIRE: BOWEL SYMPTOMS

Please complete this questionnaire to the best of your ability as it relates to any bowel symptoms you might be **currently experiencing**. For each question below, please *circle the answer that best describes how you feel*. Then, ***mark your score (0-4 points) for each answer in the column to the right.*** There is no right or wrong answer; please feel free to make notes in the margin. When you are finished, **add up the numbers in that column for your total score.**

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

I have been diagnosed with Endometriosis of the bowel: yes no **I have been diagnosed with IBS or other GI condition: yes no**

1.	How many times do you experience bowel movements during the day?	0-6	7-10	11-14	15-19	20+	
2.	A. How many times do you experience bowel movements at night?	0	1	2	3	4+	
	B. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderately	Severely		
3.	Are you currently sexually active? YES____ NO____						
4.	A. If you are currently sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always		
	B. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always		
5.	Do you have pain associated with your bowel or in your pelvis (rectum, GI tract, etc.)?	Never	Occasionally	Usually	Always		
6.	Do you have blood in stool?	Never	Occasionally	Usually	Always		
7.	A. If you have pain with bowel movements, is it usually…		Mild	Moderate	Severe		
	B. Does your pain bother you?		Never	Occasionally	Usually	Always	
8.	A. If you have urgency to move your bowels, it is usually…		Mild	Moderate	Severe		
	B. Does your urgency bother you?	Never	Occasionally	Usually	Always		
						YOUR TOTAL SCORE:	

PATIENT ASSESSMENT QUESTIONNAIRE: BLADDER SYMPTOMS

Please complete this questionnaire to the best of your ability as it relates to any bowel symptoms you might be **currently experiencing**. For each question below, please *circle the answer that best describes how you feel*. Then, ***mark your score (0-4 points) for each answer in the column to the right.*** There is no right or wrong answer; please feel free to make notes in the margin. When you are finished, **add up the numbers in that column for your total score.**

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

I have been diagnosed with Endometriosis of the bladder: yes no **I have been diagnosed with Interstitial Cystitis: yes no**

1.	How many times do you go to the bathroom during the day?	0-6	7-10	11-14	15-19	20+	
2.	C. How many times do you go to the bathroom at night?	0	1	2	3	4+	
	D. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderately	Severely		
3.	Are you currently sexually active? YES____ NO____						
4.	C. If you are currently sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always		
	D. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always		
5.	Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum)?	Never	Occasionally	Usually	Always		
6.	Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always		
7.	C. If you have pain, is it usually…		Mild	Moderate	Severe		
	D. Does your pain bother you?		Never	Occasionally	Usually	Always	
8.	C. If you have urgency, it is usually…		Mild	Moderate	Severe		
	D. Does your urgency bother you?	Never	Occasionally	Usually	Always		
						YOUR TOTAL SCORE:	

Health Related Quality of Life

The following questions are designed to measure functional health and well-being from the patient's point of view. This is a practical and efficient method to describe the burden of endometriosis on a population-based level. Please answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

Overall, how would you rate your health ***in the past 4 weeks***?

□ Excellent □Very good □Good □Fair □Poor □Very poor

During ***the past 4 weeks***, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

□Not at all □Very little □Somewhat □Quite a lot □Could not do physical activities

During ***the past 4 weeks***, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

□None at all □A little bit □Some □Quite a lot □Could not do daily work

How much bodily pain have you had in ***the past 4 weeks***?

□None □Very mild □Mild □ Moderate □Severe □Very Severe

During ***the past 4 weeks***, how much energy did you have?

□Very much □ Quite a lot □Some □A little □None

During ***the past 4 weeks***, how much did your physical health or emotional problems limit your usual social activities with family or friends?

□Not at all □Very little □ Somewhat □Quite a lot □Could not do social activities

During ***the past 4 weeks***, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

□Not at all □Slightly □Moderately □Quite a lot □Extremely

During ***the past 4 weeks***, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

□Not at all □Very little □Somewhat □Quite a lot □Could not do daily activities

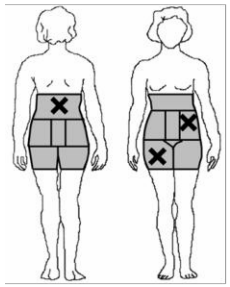
PAIN & MEDICAL HISTORY OVERVIEW

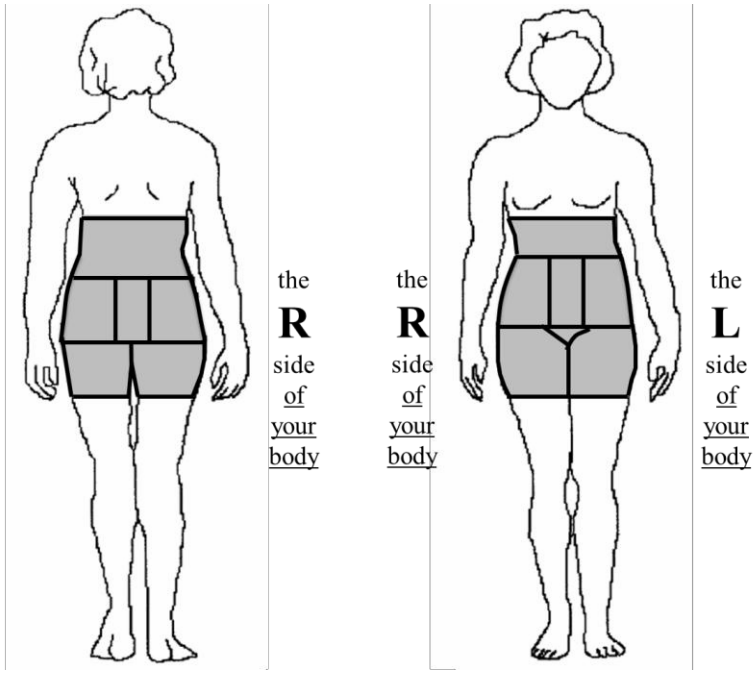
1) Please indicate if you have the following symptoms AND rate their intensity on a scale from 0 to 10 (with 0 – none, 10 – worst imaginable)		**IF YES: Circle one (1 – 10, with 1 being least pain and 10 worst imaginable)**
Have you had chronic pelvic pain (meaning pelvic pain between the thighs and umbilicus not during the period) for at least 3 months?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have painful periods that affect your daily life?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have crampy, “period-like” pain, but without bleeding?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have low back pain that gets worse with your period?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pain with bowel movements or other bowel symptoms related to your period?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pain with urination, urinary frequency, or urgency?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have any deep pain with intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have superficial pain (on insertion) with intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10
Do you have pelvic pain that lingers for several hours after intercourse?	☐ YES ☐ NO If YES then →	1 2 3 4 5 6 7 8 9 10

PLEASE RATE YOUR OVERALL QUALITY OF LIFE (0=WORST IMAGINABLE, 100=PERFECT): _____

<u>Noting the right and left side labels carefully</u>, please put an 'X' on <u>ALL</u> areas (pelvic, thoracic, sciatic, etc.) where you experience pain regularly:

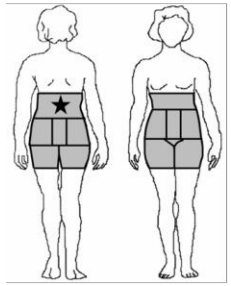
EXAMPLE

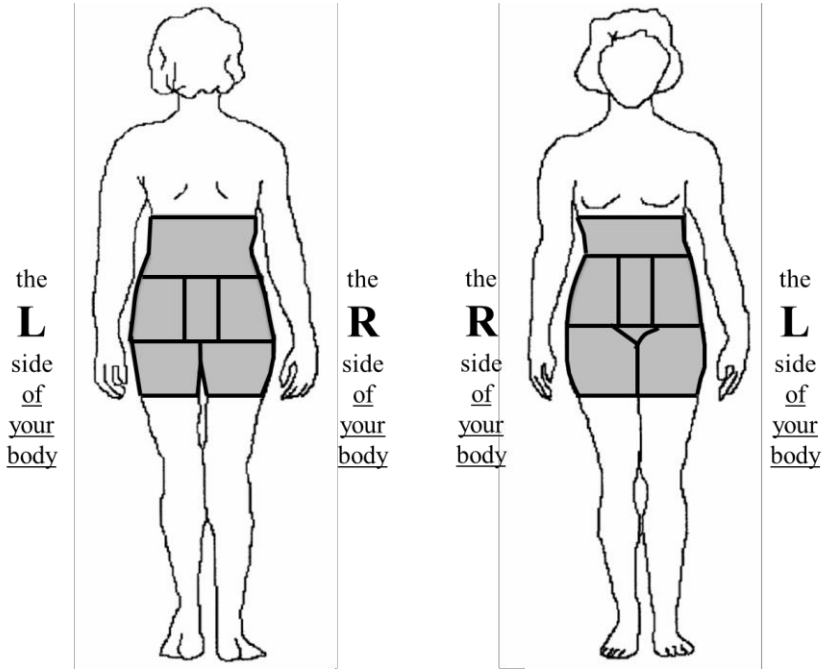




<u>Noting the right and left side labels carefully</u>, please put a star on <u>the ONE area</u> where you experience the <u>WORST</u> pain.

EXAMPLE





Diagrams adapted from The International Pelvic Pain Society Assessment Form © April 2008 and Hsu et al. 2011

MEDICAL HISTORY: Please Circle YES (Y) or NO (N)

Abnormal Pap	Y	N	Anemia	Y	N	Anesthetic	Y	N
Arthritis	Y	N	Asthma	Y	N	Bladder/ Kidney	Y	N
Cancer	Y	N	Cataracts	Y	N	Chlamydia	Y	N
Crohn's Disease/ Ulcerative	Y	N	Congenital Heart	Y	N	Congestive Heart	Y	N
Depression	Y	N	DVT (blood clots)	Y	N	Emphysema/ COPD	Y	N
Epilepsy/ Seizures	Y	N	Fibromyalgia	Y	N	Gestational Diabetes	Y	N
Glaucoma	Y	N	Gonorrhea	Y	N	Heart Attack	Y	N
Heart Murmur	Y	N	Heart Problems	Y	N	Hepatitis: Viral	Y	N
Heartburn/ GERD	Y	N	Herpes	Y	N	HIV/ AIDS	Y	N
HPV	Y	N	Hypertension	Y	N	Irritable Bowel	Y	N
Interstitial Cystitis	Y	N	Kidney Disease	Y	N	Kidney Stones	Y	N
Migraines	Y	N	Osteoporosis/ Penia	Y	N	Pulmonary Embolus	Y	N
Sickle Cell Trait	Y	N	Sickle Cell Disease	Y	N	Stroke	Y	N
Syphilis	Y	N	Thyroid Disease	Y	N	Trichomonas	Y	N
Tuberculosis	Y	N	Type 1 Diabetes	Y	N	Type 2 Diabetes	Y	N

Other medical problems not mentioned above:

SURGICAL HISTORY: Please Circle YES or NO

Appendectomy	Y	N	Gallbladder removed	Y	N	Cervical Biopsy	Y	N
Cervical Cerclage	Y	N	Abdominal Hysterectomy	Y	N	Cervical Cone Biopsy	Y	N
C-Section	Y	N	Laparoscopic Hysterectomy	Y	N	Heart Bypass Surgery	Y	N
Hernia Repair	Y	N	Vaginal Hysterectomy	Y	N	LEEP	Y	N
Mastectomy	Y	N	Hysteroscopy	Y	N	Ovarian Cyst removed	Y	N
Tonsillectomy	Y	N	D & C	Y	N	Diagnostic Laparoscopy	Y	N
Tubal Ligation	Y	N	Vulvar Biopsy	Y	N	Tube removed	Y	N
Single Ovary Removed	Y	N	Both Ovaries Removed	Y	N	Both Tubes Removed	Y	N
Video-Assisted Thoracoscopic Surgery (VATS)				Y	N	Thoracic Surgery	Y	N

Other history not specifically mentioned above:

Please circle accordingly or select "none."

Constitutional:	Fever, chills, sweats, fatigue, malaise, anorexia, weight loss	None
Eyes:	Contacts/ glasses, cataracts, glaucoma, visual disturbance, irritation, redness, yellow in eyes, color blindness.	None
Head and Neck:	Hearing loss, ringing in ears, ear drainage, earache, nasal congestion, bloody noses, snoring, sore mouth, sore throat, hoarseness, voice changes	None
Breathing:	Cough, sputum, coughing up blood, pleurisy, pneumonia, asthma, wheezing, shortness of breath on exertion, emphysema.	None
Heart & Circulation:	Chest pain, chest discomfort, shortness of breath, palpitations, irregular heartbeat, near fainting, fainting, fatigue.	None
Intestinal:	Difficulty swallowing, painful swallowing, reflux/ heartburn, nausea, vomiting, change in bowel habits, black or bloody stool.	None
Genitourinary:	Frequent urination, painful urination, waking up to urinate at night, leaking urine, difficulty starting to urinate, decreased stream, blood in urine.	None
Skin and Breast:	Rash, skin lesions, itching, dryness, skin color change, change in mole, breast lump, nipple discharge.	None
Blood:	Easy bruising, bleeding easily, swollen glands, broken blood vessels.	None
Muscles	Pain in muscles, joint pain, still joints, neck pain, back pain, muscle weakness, bone pain.	None
Nerves	Headache, dizziness, seizures, memory problems, speech problems, tingling, coordination problems, difficulty walking, tremor, weakness.	None
Psychiatric	Abusive relationship, ADHD, aggressive behavior, anorexia, anxiety, bad moods, behavior problems, bipolar, borderline personality, depression, alcoholism.	None
Glands	Diabetes, fertility problems, temperature intolerance.	None
Allergy	Rashes, hay fever, angioedema, anaphylaxis.	None

NARRATIVE SUMMARY

The narrative summary is an important part of the review process, as it is your 'voice." Be sure to include details of information you'd like us to know related to your pain/symptoms. Be sure to include prior surgeries/treatments/medications as applicable, as well as your current symptoms. Patients are encouraged to consider attaching a recent photograph as well; we like to personalize our cases as much as possible.

Please follow this page with your written narrative summary (should not exceed 3-4 pages at max). Please be sure to include your name on all pages. Thank you for the time you will spend writing this important summary for us. We appreciate you sharing your experiences so that we may better understand and try to help.

Center for
Endometriosis
Care

CURRENT CEC POLICIES & INFORMATION

THANK YOU for choosing the Center for Endometriosis Care. We know you have options and we appreciate your trust – and are very grateful for the opportunity to assist you.

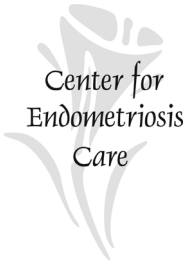
We strive to make the process of undergoing treatment at our Center as comfortable and stress-free as we can; as a result, we have developed various policies and procedures to ensure that your rights and responsibilities as a patient are protected and we are best able to serve your needs.

Following herein you will find our current policies and other documentation that relates to your care with our Center. These include:

Upon review, please sign and return these forms to us so that we may keep a copy in your medical record. Should you have any questions or concerns, please never hesitate to contact us at (770) 913-0001.

We sincerely appreciate the opportunity to become a partner in your care.

Aug 2023



CANCELLATION / 'NO SHOW' POLICY FOR OFFICE APPOINTMENTS

At Kenny R. Sinervo MD, FRCSC LLC/Center for Endometriosis Care (hereinafter referred to as 'CEC'), our goal is always to provide our patients with high quality, individualized medical care in a timely manner. In order to serve all of our patients better, we would like to advise you of our policy regarding late cancellation notice and/or 'no-shows' for office appointments. This policy enables us to render excellent service to all CEC patients and be respectful of everyone's needs.

"Late Cancellation:" notice of cancellation is considered **late** when a patient fails to cancel their appointment within at least **24 hours** of their allotted date and time

"No-Show:" when a patient **fails to be present** at the scheduled time and date of their appointment

Our entire staff spends a great deal of time preparing for your visit, and appointments are made by the CEC through use of a system that sets aside specific blocks of time just for your care. As a courtesy, we do make reminder calls for appointments, and we understand there may be times when you must miss your scheduled slot due to emergencies or unforeseen obligations. However, when patients do not show up for their appointment or fail to notify us by phone of their inability to keep the appointment at least 24 hours in advance, that time cannot be reallocated to another individual who is also in need of our care. As such, in accordance with American Medical Association[1] recommendations, our office has implemented the following policy regarding late cancellations and no-shows:

First Late Notice/Missed Appointment: if your appointment is not canceled at least 24 hours in advance or you fail to show, **you will be charged a one hundred dollar ($100) fee**; this fee is not covered by your insurance company.

Second Late Notice/Missed Appointment: if your appointment is not canceled at least 24 hours in advance or you fail to show, **you will be charged a one hundred fifty dollar ($150) fee**; this fee is not covered by your insurance company.

Third Late Notice/Missed Appointment: if your appointment is not canceled at least 24 hours in advance or you fail to show, **you will be charged a two hundred dollar ($200) fee and discharged from our practice**; this fee is not covered by your insurance company.

How to Reschedule/Cancel Your Appointment: to cancel or rebook your appointment, **you must call 770-913- 0001 within 24 hours of your scheduled appointment slot.**

Physicians do not discuss financial matters. Our staff is highly trained to discuss these issues with you.

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

1. AMA Code of Medical Ethics; Opinion 8.01. American Medical Association, Chicago, IL 60611-5885.

Center for Endometriosis Care

CEC POLICY REGARDING OFFICE VISITS

The Center for Endometriosis Care is pleased to assist you with all of your office appointment needs. Please familiarize yourself with our policy regarding this subject:

We are an out of network provider. When you come into the office for your visit, we will file a claim with your insurance company as a courtesy to you. However, this does not guarantee payment on your account. You are ultimately responsible for any outstanding amount due.

I HAVE READ AND UNDERSTAND THE POLICY LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

Center for Endometriosis Care

CANCELLATION / 'NO SHOW' POLICY FOR SURGERY

We greatly appreciate your trust in Kenny R. Sinervo MD, FRCSC LLC/Center for Endometriosis Care (hereinafter referred to as 'CEC') and choosing us for your surgery. In order to serve all of our patients better, we would like to advise you of our policies regarding surgical cancellations and 'no shows.'

Your surgery block is reserved especially for you, and much work goes into planning your procedures. The scheduling coordination process is complex and time consuming, and involves the effort of many individuals both within the CEC as well as other physicians and the hospital; we are unable to recoup the significant losses incurred by late cancellations and 'no shows.' Thus, we must adhere to our following policies. Please also note we are not always able to accommodate specific date requests; however, we will do our very best to accommodate your wishes.

PLEASE NOTE THE FOLLOWING SURGICAL POLICIES:

Surgical deposit due immediately at time of booking surgery in order to hold your date: $500.00

- If you should **cancel your surgery within 21 days**, you will be refunded your deposit **less a $250.00 administrative fee**; this fee is not covered by your insurance company.
- If you should **cancel your surgery later than 21 days** before your scheduled procedure, **you will forfeit your entire $500.00 deposit**; this fee is not covered by your insurance company.
- If you should **cancel your surgery within one week of your date due to non-medical reasons, you will forfeit your entire $500.00 deposit AND be charged an additional $500.00 to reschedule**, due to our loss of operating room time; this fee is not covered by your insurance company.
- If you should **need to move your surgery date**, you will be charged **a $100.00 change fee** in addition to your $500.00 deposit already on file; this fee is not covered by your insurance company.

If you are a 'no show' at the time of your preoperative appointment:

- Your surgery will be **canceled**, you will **forfeit your entire $500.00** deposit, and your surgery **will not be rescheduled**; this fee is not covered by your insurance company.

Physicians do not discuss financial matters. Our staff is highly trained to discuss these issues with you. Should you have questions or concerns, please contact the office directly.

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

Center for Endometriosis Care

CEC PAIN MANAGEMENT POLICY

Patient's Agreement

In an effort to provide the best care for you, we have provided general guidelines of our pain management agreement here at Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care. It is our commitment to help you have the most comfortable post-operative transition possible within the safe, medicolegal guidelines that are provided below. Please read carefully. You are required to read and acknowledge this agreement.

1. **Normally, we would expect that a patient will require pain management for 3-4 weeks post surgery. We will prescribe pain medications for up to 6 weeks after a hysterectomy or VATs. If a patient has a history of chronic opioid use, the patient will need to seek out a pain management doctor before surgery so they can manage your pain after 6 weeks post op.**
2. **Post-operative pain management is intended to cover an interval of 21-42 days depending on the case.** After this period, if pain persists and post-operative complications are not apparent, pain management will be shifted to appropriate pain management specialists while any further investigations and/or referrals are made.
3. Once pain management specialists are involved, they will control all narcotic and analgesic prescribing in order to offer the very best care. At this time, a note will be placed in the patient's chart to document that further pain management will be under the authority of these specialists, and CEC personal will refer patients to these specialists for ongoing care in this area.
4. All medications must be taken exactly as instructed and patient may not change the dosage amounts or alter the time schedule of taking the medication without first consulting with the physician and receiving updated instructions/prescriptions.
5. **Narcotics should be prescribed by only one physician's office and that only one pharmacy should be used for filling narcotic prescriptions.**
6. **The CEC will NOT refill lost or misplaced narcotic prescriptions.**
7. Prescriptions for narcotics that must be mailed will be shipped via FedEx or UPS **at a charge to the patient** ($25 for 2-day; $50 for overnight).
8. Patients must make requests for narcotic refills ***during regular office hours*** in order to allow for chart review and ensure proper documentation. **Calls for medication will be accepted from the patient only, not family members.** Please be aware that narcotics and other **prescriptions will not be phoned in after hours on weekdays, after 12pm EST on Friday, or on the weekend**. Email, social media and other inappropriate means of communicating a refill request ***will not be acknowledged***. Requests must be phoned in by the patient, during regular business hours.
9. Follow up visits may be required from the physician (or emergency room) in order to obtain a refill.
10. Patients should not operate heavy equipment or drive a motor vehicle while using narcotics and that these medications should not be combined with alcohol. Patients may be terminated from the practice (with 30 days notice) for noncompliance in taking medications including altering or forging narcotic prescriptions.

1. Either the physician or nurse must document all prescriptions for pain medication in patient office chart.
2. **Patients are not permitted to e-mail physicians directly for pain medications – instead, patients must call the office and speak with a nurse.**
3. CEC staff should be referring patients to 'pain management specialists' for continuing management, if the patient's narcotic needs exceed the immediate post-operative period.
4. If the MD believes that a special needs patient has appropriate reasons for the CEC to continue to provide narcotic/strong analgesic medications beyond the immediate post-op phase, it can be presented to and approved by the other CEC medical staff. The reasons and approval will then be documented in the patient's chart.
5. There must be proper documentation in chart of the following:
    a. All prescriptions for pain medication (including dosage, medication strength, quantity)
    b. Assessment regarding patient progress, management plan, and limits
    c. Referrals made and requested
6. **The type of medication you will be prescribed will be discussed on a case by case basis with your surgeon.**

SIGNATURE REQUIRED OF ALL REVIEW CANDIDATES:

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____
Printed Name (parent or guardian if minor) Signature

_____
Date

To be countersigned by CEC, patient and witness only at your preoperative appointment, should surgery be scheduled. Please do not sign below until you are present in our office. Thank you.

These policies have been reviewed with me at my preoperative appointment. I have read, understand and agree to adhere to the policies listed above.

_____ _____
Printed Name (parent/guardian if minor) Signature (parent/guardian if minor)

_____ _____
Witness Printed Name Witness Signature

_____ _____
CEC Staff Name CEC Staff Signature

_____
Date

Center for
Endometriosis
Care

NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Public Law 104-191

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care understands the importance of privacy and is committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We may use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan, and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. **If you have any questions about this Notice, please contact us at Heather@CenterForEndo.com.**

How our Practice May Use or Disclose Your Health Information: we collect health information about you and store it in a chart, on a computer and/or in an electronic health record/personal health record. This is known as "your medical record." The medical record is the property of this practice, but the information in your medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care the CEC provides, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management.
4. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates, if any, which contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
5. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
6. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

7. Notification & Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
8. Marketing. We do not use or otherwise disclose your personal medical information for marketing purposes.
9. Sale of Health Information. We do not sell your health information.
10. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
11. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the United States Food & Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
12. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
13. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
14. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
15. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
16. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
17. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification.

When This Medical Practice May Not Use or Disclose Your Health Information: except as described in this Notice of Privacy Practices, Kenny R. Sinervo, MD, FRCSC, LLC/the Center for Endometriosis Care will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights:

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out- of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect & Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

Changes to this Notice of Privacy Practices. We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website(s).

Complaints. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov. You will not be penalized in any way for filing a complaint. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our Privacy Officer as noted above.

I have been presented with a copy of Kenny R. Sinervo, MD, FRCSC, LLC's Notice of Privacy Policies detailing how my protected health information may be used and disclosed as permitted by Federal and State Law. I understand the Notice, and to the extent necessary, **I authorize disclosure of all my medical information with the following restrictions (note if any):**

The **following individuals have unrestricted authorized access** to my medical information (note if any):
1)
2)

This authorization will remain in effect until revoked by me in writing or to the extent action has already been taken. Further, I permit a copy of this authorization to be used in place of the original. Moreover, I assign all medical/surgical benefits to be paid to Kenny R. Sinervo, MD, FRCSC, LLC for services furnished to me by their physicians or suppliers. Additionally, I authorize any holder of my medical information to release it to Kenny R. Sinervo, MD, FRCSC, LLC. I have received, read, and fully understand this Notice:

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

Center for Endometriosis Care

TRAVEL POLICY FOR OUR INTERNATIONAL & OUT-OF-TOWN SURGICAL PATIENTS

At the CEC, your perioperative care and safety is of the utmost concern. In keeping with best medical practices, we have special considerations and restrictions for our patients traveling to Atlanta for their surgery. Please read below and plan your procedures with us accordingly and with as much flexibility as possible:

International patients flying into Atlanta

- You are required to stay in the local Atlanta area for at least **one week following your discharge** from the hospital.
- All patients not local to Atlanta **must coordinate follow-up care with their local physician** once they have returned home.
- **All patients must be accompanied** by a caregiver (parent, partner, friend etc.) throughout the duration of their stay in Atlanta.

Out-of-town patients flying in or driving to Atlanta

- You are required to stay in the local Atlanta area for at least **72 hours following your discharge** from the hospital.
- All patients not local to Atlanta **must coordinate follow-up care with their local physician** once they have returned home.
- **All patients must be accompanied** by a caregiver (parent, partner, friend etc.) throughout the duration of their stay in Atlanta.

We work diligently to obtain reduced rates at local area hotels for our patients. Please visit our website at http://centerforendo.com/accomodations for an updated list of lodging options across Perimeter Center and http://centerforendo.com/traveling-to-cec/#reservations-1 for travel tips. Be sure to mention 'medical rate' when booking; you may reference 'Northside Hospital' or 'the Center for Endometriosis Care' when reserving your room.

These requirements may vary on a case by case basis. Thank you for helping us to provide the safest care for you.

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

Center for
Endometriosis
Care

CEC POLICY ON SOCIAL MEDIA INTERACTION

Please note: this policy should not be mistaken or confused for a 'non-disclosure agreement ('NDA')'; this is a social media interaction policy. We have never had any mechanism in place either serving as or resembling an NDA. Please read on to understand our position on interacting with the CEC staff via any/all social platforms as outlined in detail herein. Thank you.

Social media offers wonderful and innovative ways for the CEC staff to interact with our patients and non-patients alike, and for us to offer positive contributions to the broader endometriosis community. However, the tenets of professionalism and patient-physician relationship must govern our interactions at all times. Recommendations instituted by oversight bodies offer ethical guidance for preserving trust in patient-physician relationships and our profession when using social media; these recommendations specifically and strongly discourage doctors and their staff from "interacting with current or past patients on personal social networking sites such as Facebook" [Federation of State Medical Boards. Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice. Euless, TX: Federation of State Medical Boards].

Subsequently, in accordance with the strict policies set forth by the American Medical Association, American College of Physicians, Federation of State Medical Boards, and Health Insurance Portability & Accountability Act (HIPAA), the CEC staff including and especially our physicians is bound to maintain a respectful and safe environment for all of our patients. This includes, but is not in the least limited to, discussing specific treatments or other personal details with potential, new or existing patients on Facebook, Twitter, LinkedIn, Instagram, etc. Similarly, preservation of professional boundaries is absolutely critical to the integrity of an appropriate patient-physician relationship. The online setting is an important tool in facilitating health discussions in the modern age, but it must be used and limited/restricted appropriately, particularly regarding the following factors: intended purpose of exchange and content of conversation; inappropriate expectations regarding response time; maintaining confidentiality; and above all else – adhering to ethical and legal requirements.

It is entirely appropriate to post general questions on our Facebook page wall, for example. It is also acceptable to engage in general, broad discussions with any staffer in a group setting where you may both be members. Conversely, it is not appropriate whatsoever to post personal details about yourself - or another individual - on any staffer's personal wall, in groups whether private or public, in 'mailbox/in-box', on pages, etc. and/or tag a CEC staff member for specific information. Doing so creates blurred professional and personal boundaries, violates privacy, and lessens the quality of our interaction with you.

You can help us to protect your privacy, maintain appropriate and professional ethical boundaries with our surgeons and staff, and safeguard our digital encounters by avoiding use of 'tagging' staff in posts, seeking specific advice or treatment information about your case via groups or 'inbox' - or personal walls - instead of calling our office via proper protocol, and by following proper channels in seeking new or ongoing care with us. We use social media as a tool to augment care - not as a replacement. While we recognize patients and non-patients alike desire ease of communication with our staff, as professionals, we must be cognizant of not trading communication quantity for quality.

Please help us to help you by using your best judgment regarding personal communications between you and our staff and surgeons online at all times. Online technologies present both opportunities and challenges to professionalism – they offer innovative ways for our staff to interact with our patients and can positively affect the health of our broader community, but the tenets of professionalism and of the patient–physician relationship should govern all interactions.

As such, your use of CEC Social Media Sites [hereinafter referred to as 'site(s)'] is implied acceptance of this Policy to wit:

You are prohibited from posting any personal health content on any CEC site(s). Moreover, you agree that you will not:

- violate any local, state, federal and international laws and regulations, including but not limited to copyright and intellectual property rights laws regarding any content that you send or receive via this Policy;
- transmit any material (by uploading, posting, email or otherwise) that is unlawful, disruptive, threatening, profane, abusive, harassing, embarrassing, tortuous, defamatory, obscene, libelous, or is an invasion of another's privacy, is hateful or racially, ethnically or otherwise objectionable as solely determined in CEC's discretion;
- impersonate any person or entity or falsely state or otherwise misrepresent your affiliation with a person or entity;
- transmit any material (by uploading, posting, email or otherwise) that contains software viruses, worms, disabling code, or any other computer code, files or programs designed to interrupt, destroy or limit the functionality of any computer software or hardware or telecommunications equipment; harass another; or collect or store, or attempt to collect or store, personal data about third parties without their knowledge or consent; or to share confidential pricing information of any party.

The CEC reserves the right to monitor, prohibit, restrict, block, suspend, terminate, delete, or discontinue your access to any of our sites, at any time, without notice and for any reason and at its sole discretion. You understand and agree that CEC may disclose your communications and activities with us in response to lawful requests by governmental authorities, including Patriot Act requests, judicial orders, warrants or subpoenas, or for the protection of CEC rights.

You agree that in the event that CEC exercises any of its rights hereunder for any reason, the Center for Endometriosis Care/Kenny R. Sinervo, MD FRCSC LLC has no liability to you.

You expressly acknowledge that you personally assume all responsibility related to the security, privacy, and confidentiality risks inherent in sending any content over the internet. By its very nature, a website and the Internet cannot be absolutely protected against intentional or malicious intrusion attempts. CEC does not control third party sites or the Internet over which you may choose to send us confidential personal or health information or any other content and therefore, we do not warrant any safeguard against possible interceptions or compromises to your information.

When posting any content on any site(s), think carefully about your own privacy in disclosing detailed or private information about yourself and your family.

You agree that any claim or dispute relating to your posting of any content regarding our Center shall be construed in accordance with the laws of the State of Georgia without regard to its conflict of law's provisions and you agree to be bound and shall be subject to the exclusive jurisdiction of the local, state or federal courts.

Thank you so much for taking the time to read and appreciate our position on this matter.

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

Center for Endometriosis Care

CEC POLICY REGARDING ADMINISTRATIVE FEES

The Center for Endometriosis Care is pleased to assist you with all of your administrative needs throughout the planning of your surgery and thereafter. In some instances, administrative fees may be applied. Please familiarize yourself with our policies regarding this subject:

Medical Records Retrieval:
After your surgery, you will be provided with two sets of operative records and reports at no cost; one for you and one for your local provider. We are happy to accommodate your future requests for any additional copies that you may wish to obtain at a later date. We adhere to Georgia state law regarding costs for additional retrieval and copying costs, as follows:

GEORGIA CODE O.C.G.A. § 31-33-3
Costs of copying and mailing; patient's rights as to records:

Administrative Fee:	$25.88
Pages 1 - 20:	$0.97 per page
Pages 21 - 100:	$0.83 per page
Pages 101+:	$0.66 per page
Certification Fee:	$9.70 (only if required)
Secure mail Fee:	$20.00

Note: Rates do not apply to records requests necessary to make or complete an application for a disability benefits program or vocation rehabilitation program.

Requests must be phoned to (770) 913-0001 with at least 30 days notice. Applicable charges will be obtained upfront and you will be emailed or otherwise sent any release forms that might be required prior to release of your records. Thank you for your understanding.

FMLA/Disability Paperwork:
We are happy to assist you with your family leave or other administrative paperwork related to your surgery with us. **The standard, nominal fee of $40.00 (payable for *each* encounter/documentation) will be collected upfront prior to our assistance with your forms and/or any additional ongoing paperwork needs. Please** call us at (770) 913-0001 with ample notice and we will be delighted to assist you in this regard.

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____
Printed Name (parent or guardian if minor) Signature

_____
Date

Center for Endometriosis Care

CEC POLICY & CONSENT FOR EMAIL

The Center for Endometriosis Care offers patients the opportunity to communicate by email **for non-urgent matters**. This form provides information about the risks of email and guidelines for email communication.

RISKS

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- ☐ E-mail can be circulated, forwarded and stored in paper and electronic files.
- ☐ Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- ☐ E-mail can be received by unintended recipients.
- ☐ E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- ☐ E-mail can be used to introduce viruses into computer systems.

You should not communicate with Center for Endometriosis Care personnel via email if any of the above risks concern you.

GUIDELINES FOR EMAIL COMMUNICATION

- ☐ Include the general topic of your message in the subject line of the e-mail (e.g., 'appointment').
- ☐ **Include your name, date of birth, phone number in the body of the email.**
- ☐ The content of the **email should only be used for non-sensitive, NON-MEDICAL, and non-urgent issues**.
- ☐ The Center for Endometriosis Care attempts to read and respond within 72 hours to any e-mail. However, we cannot guarantee that any email will be responded to within any particular time.
- ☐ Inform The Center for Endometriosis Care of changes in your email address.

Please complete all the fields marked with asterisks [*]:

***Patient Name:** _____

***Phone number:** _____

***Email address:** _____

I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date

Center for Endometriosis Care

CEC CREDIT CARD ON FILE (CCOF) POLICY & INFORMATION

The Center for Endometriosis Care/Kenny Sinervo, MD FRCSC LLC (hereinafter referred to as "CEC") has joined the growing number of practitioners in adopting a policy requiring a credit card to be held on file in order to confirm your office appointment. Effective as of 10/01/2022, this new standard is being implemented by scores of healthcare providers and medical practices around the country, both at the primary care and specialist level like ours. **The following information describes this policy in detail and answers common questions you may have relative to the policy.**

The CEC is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. Henceforth, we require all patients to provide us a credit card to keep on file ("CCOF") prior to their appointment. **This card can/will be charged for the following reasons:**

- **To collect outstanding office appointment deposits and payments/balances due, and/or**
- **To collect no-show and/or late cancellation charges as applicable**

Similar to hotels and car rental agencies, you are asked for your card number at the time you book your appointment with us; this information will be maintained in our PCI/HIPAA-compliant, secure recordkeeping system and utilized only to collect any balances owed by you as outlined above. This is advantageous to you, as it streamlines our billing process, thereby allowing us to pass these cost-savings on to our patients, and by making it easier, faster and more efficient for you to pay your bill with us in full. This in no way compromises your ability to dispute a charge or question your insurance company's determination of any payment(s) as may be applicable. Please read the following very carefully regarding the summary of potential charges to your card.

Please note the following: The CEC is an out-of-network provider. That means, your insurance company may not cover the full - or any - costs of your appointment with us. As such, typically your new patient in-office appointment will cost you **$500. Our new patient appointment consists of a consultation and an ultrasound – if an ultrasound is not completed, or non-standard blood work is done, this amount may be different – but a minimum of $350 will be due at time of service.** This amount will be communicated to you at the time of your booking. With CCOF, your card can be used for your co-pays, deductibles, non-covered services paid out of pocket, and/or for portions of bills not covered after insurance has paid out its portion, if any. You are responsible for outstanding balances, not your insurance company, and your card on file will be used to collect this amount in full. We will bill your insurance for this office visit, but cannot guarantee payment. If you have any blood work or other services outside the consultation and ultrasound, you will owe these amounts if your insurance does not cover them. **If you do not book surgery within 6 months of your office visit, any remaining balance is your responsibility. If you do not book surgery within 6 months of your office visit, you will be required to pay an additional $500 surgical deposit should you book surgery beyond the 6 months.**

Late/No-Show Appointment Costs-at Kenny R. Sinervo MD, FRCSC LLC/Center for Endometriosis Care, our goal is always to provide our patients with high quality, individualized medical care in a timely manner. The following policy enables us to render excellent service to all CEC patients and be respectful of everyone's needs. **Please read our cancellation/no-show/appointment policies and charges below very carefully:**

- "Late Cancellation:" notice of cancellation is considered late when a patient fails to cancel their appointment within at least 24 hours of their allotted date and time.
- "No-Show:" when a patient fails to be present at the scheduled time and date of their appointment. No Show telehealth appointments will be charged the full amount of $250.00, which is due at time of booking of the appointment.

- In addition, if you are late for your appointment time with us by more than 15 minutes, we will do our best to accommodate you. However, please understand that it may be necessary for us to reschedule your appointment for a later date.

As a courtesy, we do send notifications and/or make reminder calls for appointments, and we understand there may be times when you must miss your scheduled slot due to emergencies or unforeseen obligations. However, when patients do not show up for their appointment or fail to notify us by phone of their inability to keep the appointment at least 24 hours in advance, that time cannot be reallocated to another individual who is also in need of our care. **As such, in accordance with American Medical Association recommendations, we execute the following policies/charges regarding late cancellations and no-shows:**

Missed Telehealth Appointments:
We will keep your $250.00 telehealth fee ran at time of booking if you fail to show for this appointment. This fee is not covered by your insurance company.

First Late Notice/Missed Appointment: if your appointment is not canceled at least 24 hours in advance or you fail to show, **you will be charged a one hundred dollar ($100.00) fee** to the credit card on file; this fee is not covered by your insurance company.

Second Late Notice/Missed Appointment: if your rescheduled appointment is not canceled at least 24 hours in advance or you fail to show, **you will be charged one hundred and fifty dollar ($150.00) fee** to the credit card on file; this fee is not covered by your insurance company.

Third Late Notice/Missed Appointment: if your rescheduled appointment is not canceled at least 24 hours in advance or you fail to show, **you will be charged two hundred dollar ($200.00) fee to the credit card on file and discharged from our practice**; this fee is not covered by your insurance company.

How to Reschedule/Cancel Your Appointment: to cancel or rebook your appointment, you must call 770- 913-0001 during normal business hours within 24 hours of your scheduled appointment slot. Please do not email or contact our physicians directly regarding appointments or financial matters. Our staff is highly trained to discuss these issues with you and assist you with your appointment bookings.

Moreover, it is your responsibility to ensure that the card you have on file with our office is not expired or canceled and has an appropriate amount of available credit. Please call our office immediately if you need to update your credit card on file. If your payment is declined, a **$35 declined payment fee will be applied to your account and a warning letter sent. If we receive no response within 30 days of the letter, your account will be turned over to a collection agency.**

We understand you may have additional questions. Please read on:

I have never had a physician's office ask to keep my credit card on file. Why is this being implemented? Although this policy may be new to you, you will soon see it happening at more and more of your doctor's offices, especially as insurance reimbursements are declining and patient responsibility amounts are increasing. We realize this is an emerging policy; however, it is no different from leaving your credit card on file with a hotel or iTunes, for example, which only charges you when balances are due. As any other business, we need to ensure that we have a guarantee of payment on file for each patient in our practice, and we only charge you when you have a balance due to our office. This may be a departure from what you have become accustomed to, but it is not uncommon for many medical practices, imaging centers, outpatient surgical centers and other providers to now require a credit card on file.

I always pay my bills! Why me? We have thousands of wonderful patients from around the globe, and we know that almost all of our patients are responsible individuals who their deposits and balances due in a swift and timely manner. Unfortunately, this is not always the case 100% of the time, and so we must apply the same policy to all patients in our care. ***Please understand this is not personal.***

How will I know how much you are going to charge me? For every visit, you will be advised of the maximum charge(s) you can expect to pay; additional amounts are noted above for no-show and/or late cancellations penalties you can also expect to pay. Please understand: this is **not** the same as 'signing a blank check' with our office. You will be advised as to the specific amount(s) to be charged at the time you book your appointment.

What about identity theft and privacy? Under PCI and HIPAA, we comply with the strictest of rules and guidelines in terms of protecting your privacy and credit card information. Because of our legal obligations and commitment to protecting your data, our office is far more secure than any retail establishments, for example, and other resources which also hold your credit card information.

I don't have a credit card. What should I do? You are welcome to send your deposit for your appointment in advance, in the amount of $250, and then pay your balance due of $250 with cash or check visit at the time of your appointment.

My insurance company wants to know if this policy is legal, and so do I. Is it? Yes, most certainly. Having a credit card on file system at your physician's office is completely legal, and in fact, is becoming the standard, just as it is for hotels and car rental companies, for example. We have every right to collect patient-owed balances due for appointments, no-shows and/or late cancellations, and/or other amounts due for care and services rendered by the CEC.

What if I refuse to participate in your credit card on file program? Our credit card on file policy is mandatory for all CEC patients, as outlined above. We can no longer afford to practice as we have in the past, and it is our sincere hope that our patients can understand and accept this. Patients who cannot accept policies and procedures at our, or any of their doctor's offices, may benefit from seeking care at more like-minded practices. We regret the need to institute this policy, but unfortunately, it is necessary in today's healthcare environs. We appreciate your understanding and support.

Still have questions? We want to help. Please feel free to contact us via phone at (770) 913-0001 or email and a member of our highly qualified, professional staff will do all we can to answer your questions and assuage any concerns you may have regarding this or any other office policy our practice adheres to. Thank you.

Patient Memorandum of Understanding at Time of Appointment Booking:
I HAVE READ AND UNDERSTAND THE POLICIES LISTED ABOVE:

_____ _____

Printed Name (parent or guardian if minor) Signature

_____

Date