



Paul J. MacKoul, MD
Gynecologic Oncology
Board Certified

Dear Valued Patient,

Welcome and thank you for choosing the Women's Surgery Center for your medical appointment. Whether you were referred by your primary care doctor, or you found out about us on your own through a personal contact, advertising or your internet research, we are glad that you have chosen us to discuss your options for your unique gynecological condition. At WSC, we are committed to improving our patients' surgical experience through the use of "minimally invasive" techniques.

Advanced Laparoscopic Surgery offers women an alternative to open surgery for a full range of gynecological conditions, including:

- uterine fibroids
- ovarian cysts
- endometriosis
- pelvic pain
- ovarian, cervical and uterine cancers.

We specialize in utilizing this technique for even the most complex gynecologic problems. Since 1998, we have performed over 3500 successful surgeries, with less than one percent of these procedures requiring conversion to an open procedure.

We will be with you every step of the way with medical excellence and sincere compassion. Please visit our website for information about our practice, many gynecological conditions, cancer and recent research, therapy and surgical options. Our web address is www.WomensSurgeryCenter.com. We look forward to meeting you at your appointment. Please call us if you have any questions.

Pre-appointment check list:

- Bring your insurance cards and picture ID
- Please FAX all medical records related to your current problem or condition to our medical records fax line: 410-990-4484 at least three business days before your appointment.
- Bring any reports or results which you could not fax pertaining to the reason for your visit (i.e. sonogram reports, pap smear results, blood work or pathology reports.)
- Bring a list of all medications that you are currently taking (including over-the-counter remedies, vitamins and herbal supplements.)
- Write down any questions or concerns that you may have to discuss with your physician.
- If you wish, bring someone with you to help listen to your physician's comments and responses to your questions.
- Take the driving directions to the Women's Surgery Center location for your appointment with you.
- Please complete and bring the preceding pre-registration forms with you.



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PATIENT INFORMATION: (Please fill in all information completely)

Last Name: _____ First Name: _____ MI: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Phone #s – Home: _____ Work: _____ Cell: _____
 Email: _____ Pharmacy: _____ Pharmacy Telephone: _____
 Date of Birth: _____ SSN: _____ Marital Status: S M D W
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Primary Care Physician (First & Last Name) _____
 Referring Physician (First & Last Name) _____ Phone: _____
 How did you first learn about the Women's Surgery Center?
 Doctor Referral Insurance Website Internet Search Friend/Family
 Advertisement Hospital Referral Seminar Other _____

INSURANCE INFORMATION: (Please fill in all information completely)

Primary Insurance Company Name: _____ Co-pay \$ _____
 Claims Address: _____
 ID#: _____ Group#: _____
 Policy Holder Name: _____ Relationship: _____
 Policy Holder's DOB: _____ Policy Holder's SSN: _____
 Policy Holder's Employer: _____
Secondary Insurance Company Name: _____ Co-pay \$ _____
 Claims Address: _____
 ID#: _____ Group#: _____
 Policy Holder Name: _____ Relationship: _____
 Policy Holder's DOB: _____ Policy Holder's SSN: _____
 Policy Holder's Employer: _____

PATIENT'S AUTHORIZATION:

I authorize the Women's Surgery Center (WSC) (Dr. Paul J. MacKoul) to apply for benefits on my behalf for services rendered by WSC from my insurance company, and that payment is made directly to Paul J. MacKoul. I certify that the information I have reported with regards to my insurance coverage to be true and correct and further authorize the release of any necessary information (to include medical information) for any related claims. I further understand that if my insurance plan requires me to obtain a referral and if I do not have the necessary referral with me at the time of service, or if my referring physician will not issue a referral, I am responsible for paying all fees for services owed to WSC. I understand that if I do not have out-of network benefits under my insurance plan and if WSC or attending physician of WSC is not a participating provider under my insurance plan, I am responsible for all fees for services rendered by the physicians of WSC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. Any payments from my insurance carrier made to me for services provided by any member of WSC will be surrendered to WSC. This includes office visits, surgery or other procedures.

Signature _____

Date _____

I have received a copy of the Women's Surgery Center's Financial Policy. _____ (Pt Initials)



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NOTICE OF PRIVACY PRACTICES

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. This notice takes effect on the date it is signed by the patient and remains in effect until we replace it or, it is revoked in writing by the patient.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

The Law Require Us To:

- a. Keep your medical information private.
- b. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- c. Follow the terms of the current notice.

We Have the Right To:

- a. Change our privacy practices and the terms of this notice at anytime, provided that the changes are permitted by law.
- b. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
- c. Before we make an important change in our privacy practices, we will change this and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

This section describes ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purposes not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time in writing to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to Center for GYN Surgery, doctors, nurses, technicians, medical students, other people who are taking care of you, or other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes, but not limited to:

Notification: We may use and disclose medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we



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will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who had dies with a coroner, medical examiner, funeral director or an organ or organ donor procurement organization.

Court Orders and Judicial and Administrative Proceedings, Law Enforcement: We may disclose information in response to a court or administrative order, subpoena, discovery request, or other law enforcement officials.

Public Health Activities: As required by law, we may disclose health information to public health or legal authority's charges with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Workers Compensation and Disability Determination: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation, disability determination, or authorized activities.

4. YOUR INDIVIDUAL RIGHTS

You have the right to:

- a. Look at or receive copies of certain parts of your medical information. You must make your request in writing. If you request copies, we will charge you an appropriate fee and postage if you want the copies mailed to you.
- b. Receive a paper copy of this Notice at any time. You may obtain a copy of this Notice from the Women's Surgery Center.
- c. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency or law).
- d. Revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and revoke this authorization, the insurance company has the right to contest my claims under the insurance policy and I will be made liable for payment of all charges for any and all serviced rendered to me by the medical providers or staff of the Women's Surgery Center.

I have read and understand the content of the Privacy Policy and I agree with all the terms stated within the authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the policy with the Women's Surgery Center.

Patient/Guardian Signature

Date



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FINANCIAL POLICY

Effective March 21, 2007

The Women's Surgery Center is committed to excellent patient care. The following guidelines will provide you with specific information regarding our financial policies. We believe that your understanding of these policies is important to our professional relationship.

Co-Pays, Deductibles, and Fees: All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered. If you are unable to pay at your visit, we will bill you with an additional \$10.00 processing fee. For your convenience, our office accepts cash, personal checks, Visa and MasterCard.

Office Appointment Cancellations: We charge \$75.00 for missed appointments, unless canceled 24 hours in advanced. This fee is not billed to your insurance company and must be taken care of prior to your next appointment.

Surgery Cancellations: Once your procedure has been scheduled, cancellation of your surgery (for any reason other than medical illness) will result in a \$1,000.00 cancellation fee.

Returned Checks: A \$35.00 returned check service charge will be assessed for a dishonored check. This service charge is in addition to any other amount due. This fee is not billed to your insurance company and must be taken care of prior to your next appointment.

Release of Medical Records: You will be charged \$.68 per page as well as a \$20 processing fee plus postage for your records. This charge must be paid before the records can be released. Your request will be processed in five to seven business days.

Disability and/or FMLA Forms: You will be charged \$25 completion for 3 pages, additional charges apply for additional information. This charge must be paid before your paperwork is processed. We will complete this request within five to seven business days.

Past due balances: Outstanding balances are due within 30 days, unless prior arrangements have been made with the billing department. Seriously past due accounts or those failing to honor the agreed-upon payment terms will be sent to a collection agency. If your account is sent to collections, a 33% fee will be added to the outstanding balance along with any other collection fees incurred. You must pay all past due amounts before subsequent appointments can be scheduled. In addition, payment in full will be expected at the time of service for any future services.

Insurance Coverage: Your health insurance is an agreement between you and your insurance company. They will provide you with an EOB (Explanation of Benefits) to explain the services they cover. Please inquire to the receptionist and/or billing department to ensure the provider participates with your plan. If the provider participates with your insurance company, all services performed in our office and at the hospital will be billed directly to the insurance company unless we have received prior notification of non-covered services. All co-pays and deductibles are your responsibility. Co-pays are due at the time of the visit. Deductibles will be billed to you. We will not be able to bill an insurance company that we do not participate in, nor can we accept payment from them as payment for services performed.



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If we do not participate with your insurance company and you have out-of-network benefits, you may receive a check directly from the insurance company for services performed. You must turn this payment over to the Women's Surgery Center along with a copy of the Explanation of Benefits. We will not balance bill for any amounts not covered with the out-of-network benefit as long as the payment you receive is given in full to the Women's Surgery Center. Please have your insurance card available at each office visit. Inform the receptionist if you have had a change in insurance since your last visit so we can bill the appropriate parties. Any balance not covered by the insurance company becomes your responsibility. Payment for office visits is due at the time of the visit. We will provide you with an itemized bill so that you may submit the charges to your insurance company.

Referrals: If your insurance requires a referral, it is your responsibility to obtain one prior to your appointment. If a referral is not presented at the time of service, you will be responsible for payment in full for those services not covered.

Please contact our billing department at the Women's Surgery Center if you have specific questions or concerns. When calling, please have your account number available so that we may serve you more efficiently.

I have read and fully understand the financial policy set forth by the Women's Surgery Center and I agree to the terms of the Financial Policy. I understand that the terms of the policy may be amended by the Women's Surgery Center at any time without prior notification.

Patient/Guardian Signature

Date

Witness Signature

Date



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NOTICE:

The providers at the WOMEN'S SURGERY CENTER are considered Specialists, therefore if you have an HMO or POS plan, please be sure to bring an insurance referral with you to your scheduled appointments.

You will need to contact your Primary Care Physician to obtain your referral. You will be responsible for payment for services rendered without a referral (if required).



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WOMEN'S SURGERY CENTER, LLC

Paul J MacKoul, MD

NEW PATIENT INTAKE FORM

Version # 5/21/09

Patient Name: _____ Date of Birth: _____ Today's Date: _____

What is the main reason for your visit today?

PAST MEDICAL HISTORY Please check (or circle) each item if it has been or is currently a problem for you

<input type="checkbox"/>	Abnormal pap smear	<input type="checkbox"/>	GERD / Heartburn/ Reflux	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Acne	<input type="checkbox"/>	Hashimoto's thyroiditis	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Pulmonary embolism
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Seizure disorder
<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	Hormone replacement therapy	<input type="checkbox"/>	Sex. transmitted disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Back pain	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	Vaginal problems
<input type="checkbox"/>	Cardiac arrest	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	Weight change
<input type="checkbox"/>	Cardiac cath	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Cancer (please list)
<input type="checkbox"/>	Cardiac disease	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>	
<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	List any other problem(s):
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Molar Pregnancy	<input type="checkbox"/>	
<input type="checkbox"/>	Deep vein thrombosis	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	

PAST SURGICAL HISTORY: Please check each surgery and give month/year of surgery.

Year	Surgery	Year	Surgery

OBSTETRICAL HISTORY:

_____ Live births # _____ vaginal delivery # _____ c-section
 Miscarriage(s) YES / NO # _____ Abortion(s) YES / NO # _____

Briefly indicate why you needed a C-Section?



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GYNECOLOGICAL HISTORY:

Have you had abnormal pap smears in the past? YES / NO. If yes – when and what was done about it? _____

Any history of frequent or recurrent vaginal infections? YES / NO. If yes-please explain _____

Any history of Pelvic Inflammatory Disease? YES / NO. If yes, when _____

Any history of sexually transmitted disease? YES / NO. If yes, please explain _____

Have you ever used an IUD for birth control? YES / NO, If yes, when _____

Have you ever taken birth control pills? YES / NO.

MEDICATIONS

Please list all currently prescribed medications with dosage and how often you take them. Also include medications you take that do not require a prescription, vitamins, herbs, etc.

Medication	Dose/Strength	How often

ALLERGIES: Do you have any allergies? YES / NO If yes- please list below:

Drug allergies _____

Circle any of the following if applicable: Environmental allergies Seasonal allergies

Date of last PAP smear _____ Results _____

Date of last Mammogram _____ Results _____

Date of last DEXA (Bone Density) scan _____ Results _____

Have you had a colonoscopy? YES / NO IF yes, date _____ Results _____

Are you MRSA (Methicillin Resistant Staphylococcus aureus) Positive YES / NO

Are you VRSA (Vancomycin Resistant Staphylococcus aureus) Positive YES / NO

We are gathering specific information about FIBROID TREATMENT. If you are here for treatment of your fibroids, please answer the following:

Please circle any of the following treatments you have already had as treatment for your fibroids? Endometrial ablation Embolization
 Oral Contraceptives Prior surgical removal (hysteroscopy, Myomectomy)

Are you interested in any surgical procedures? _____

Are you interested in fibroid removal? YES NO

Are you interested in future fertility? YES NO