KENNY R. SINERVO, MD FRCSC LLC
Center for Endometriosis Care

A COEMIG-Designated Center of Excellence in Minimally Invasive Gynecologic Surgery
A Center of Expertise in Endometriosis
6105 Peachtree Dunwoody Road | Building B, Suite 230 | Atlanta, GA 30328
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Web: CenterForEndo.com | CenterForEndometriosisCare.com
Ken R. Sinervo, MD, MSc, FRCSC, ACGE, Medical Director
Robert B. Albee, Jr., MD, FACOG, ACGE, Founder
Nicholas Kongoasa, MD, FACOG, Associate

Thank you for trusting our Center with your potential care. We are here to help any way we can, and consider it a privilege to be part of the endometriosis community. We hope to help you regain your quality of life and will do what we can to assist you. We ask you to complete all forms herein and bring them to your appointment. If you have any questions, please don't hesitate to contact us any time!

Please bring the following to your appointment:
- Your surgical or gyn office records to the full extent possible;
- The enclosed, completed forms; and
- Your insurance card (if any)

For your convenience, please make a copy of these materials so that you can maintain a set for yourself.

We are located at:
The Center for Endometriosis Care
6105 Peachtree Dunwoody Road | Building B, Suite 230 | Atlanta, GA 30328
PHONE (770) 913-0001

CEC Prospective Patient Information Form

Thank you for choosing the CEC for your care! We are pleased to welcome you as a patient.

Today's Date: _____

Whom may we thank for your referral to the CEC? _____

What is your primary reason for seeking consultation for surgery for suspected or known endometriosis (please circle only one)? PAIN FERTILITY

Last Name: _____ First Name: _____

Maiden/Other as may Appear on Records: _____

Current Age: _____ Date of Birth: _____

Full Mailing Address (Street/PO Box/Mailstop, City, State & Zip Code; Include Country if outside United States:

_____

_____

Primary E-mail Address: _____

Preferred Phone Number:_____ Secondary Phone Number:_____

Occupation (if Student, Indicate Full or Part-time):_____

Employer (if Student, School Name):_____

Employer Address:_____

Employer Telephone #:_____

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

In accordance with the current 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. This information is completely voluntary and strictly confidential, and this data is never shared outside the Center for Endometriosis Care for any reason. 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. Your disclosure is completely optional and voluntary. Thank you.

Do you self-identify as: Female / Intersex / Transgendered
Do you self-identify as: Lesbian, gay or homosexual / Straight or heterosexual / Bisexual / Other

Relationship/Marital Status (circle one): Single / Married / Partnered/Living Together / Divorced / Widowed / Other

Parent / Guardian / Spouse / Partner Information Form

Full name, including middle: _____

Date of Birth/Age: _____

Complete Mailing Address: _____

E-mail address(es): _____

Home Telephone #:_____Cell Phone #:_____

Occupation:_____

Employer:_____

Employer Address:_____

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

Insured's Name:_____

Relationship to Patient:_____

Name of Insurance Company:_____

Complete Mailing Address: _____

Telephone #:_____

Identification #:_____ Group #:_____

Secondary Insurance Information (if applicable)

Insured's Name:_____

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:

_____ _____

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	*Type of Reaction*

Attach additional sheets as needed.

Symptom Checklist/Experiences

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 2016), 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.*

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 you have experienced. Choose one box for each symptom. "Crippling pain" is so bad it keeps you from performing daily tasks or severely limits activity at least one day per month.

Pelvic Pain (not during menses)
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Menstrual Cramps
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Pain with deep penetration during intercourse
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Pain during bowel movements
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Constipation
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Diarrhea
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Intestinal cramping
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Bladder Pain
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Pain with exercise
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Backache
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

Tenderness on Pelvic Exam
❑ Does not apply ❑ slight ❑ moderate ❑ severe ❑ crippling

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

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**

		0 points	1 point	2 points	3 points	4 points	Score
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**

		0 points	1 point	2 points	3 points	4 points	Score
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:	

CEC PAIN MANAGEMENT POLICY

PLEASE READ CAREFULLY, SIGN & RETURN YOUR SIGNATURE SHEET WITH YOUR FORMS.

Version as of 3/29/16

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. **Post-operative pain management is intended to cover an interval of 90 days.** 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.
2. 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.
3. 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.
4. Narcotics should be prescribed by only one physician's office and that only one pharmacy should be used for filling narcotic prescriptions.
5. **The CEC will NOT refill lost or misplaced narcotic prescriptions.**
6. Prescriptions for narcotics will NOT be mailed to patients (they will be sent via FedEx with signature required).
7. During the 90 post-op days, 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 12 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.
8. Follow up visits may be required from the physician (or emergency room) in order to obtain a refill.
9. 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.

Physician's Responsibility

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 90-day 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 90 days, 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. Percocet 7.5/500 or 10/500 should be written 1-2 tablets q 4-6 hours not to exceed 8 tablets/day (due to acetaminophen toxicity).

I have read, understand and agree to adhere to the policies listed above:

_____	_____	_____
Printed Name	Signature	Date

NOTICE OF PRIVACY PRACTICES

Effective Date: 3.29.16

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. 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.
4. 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.
5. 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.
6. 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.
7. Marketing. We do not use or otherwise disclose your personal medical information for marketing purposes.
8. Sale of Health Information. We do not sell your health information.

9. 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.
10. 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.
11. 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.
12. 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.
13. 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.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. 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.
17. 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.
18. 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.
19. 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.
20. 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)

SIGN AND RETURN THIS PAGE. 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:

_____	_____	_____
Printed Name	**Signature**	**Date**

Patient Representative (*if signed by other than patient*) _____
Relationship to Patient

CEC POLICY ON SOCIAL MEDIA INTERACTION

PLEASE READ CAREFULLY, SIGN & RETURN YOUR SIGNATURE SHEET TO THE CEC WITH YOUR RECORDS REVIEW PACKAGE.

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; April 2012.]

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, 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.**

As a professional medical office and surgical practice, we have staff on call 24/7/365 ready to assist you with your personal needs both during normal business hours and thereafter. It is never appropriate or permissible to communicate your needs via open channels vis-a-vis social media or outside the normal channels of professional conduct. We use social media as a tool to augment in-person 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 and has the same effect as if you had actually physically signed an agreement. 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, adefamatory, 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.

THIS POLICY MAY BE UPDATED AT ANY TIME WITHOUT NOTICE.

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 Signature

_____

Date

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. **Your receipt of this Policy is your implied acceptance and has the same effect as if you had physically signed it.**

"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 surgeons and staff spend 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 cancelled at least 24 hours in advance or you fail to show, **you will be charged a twenty-five dollar ($25) fee**; this fee is not covered by your insurance company.

Second Late Notice/Missed Appointment: if your appointment is not cancelled at least 24 hours in advance or you fail to show, **you will be charged a fifty dollar ($50) fee**; this fee is not covered by your insurance company.

Third Late Notice/Missed Appointment: if your appointment is not cancelled at least 24 hours in advance or you fail to show, **you will be charged a seventy-five dollar ($75) 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 770-9130001 within 24 hours of your scheduled appointment slot.**

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

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

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