Nikolas G. Capetanakis, D.O.

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

MENSTRUAL HISTORY	YES	NO
Regular periods		
Pain with period		
Bleeding between periods		
Cramps		
Mood swings/irritability		
Weight gain		
Breast tenderness		
Age at first period		

Period is: (circle) Light / Moderate / Heavy / Clots

GYNECOLOGICAL HISTORY	YES	NO
History of Abnormal Pap		
Resulting procedures performed?		

_____

UTERINE ABNORMALITIES	YES	NO
Infection of the tubes/uterus		
Uterine fibroids		
Ovarian cysts		
Endometriosis		
Cervicitis		

SEXUALLY TRANSMITTED DISEASES	YES	NO
Gonorrhea		
Syphillis		
Chlamydia		
Genital Herpes		
Genital Warts		
Trichomonas		

CONTRACEPTIVE HISTORY

HAVE YOU USED:	YES	NO
Pill		
IUD		
Diaphragm		
Condom		
Nuva-Ring		
Tubal ligation		
Depo Provera		

Problems/Side Effects _____

_____

OBSTETRICAL HISTORY	NUMBER OF:
Total Pregnancies	
Full Term Pregnancies	
Preterm Pregnancies	
Miscarriages	
Abortions	
Living Children	

PERSONAL MEDICAL HISTORY	YES	NO	WHEN
Diabetes			
Thyroid problems			
Cancer			
Heart Disease			
Breast disease/mass			
Stroke			
Anemia			
Bladder or Kidney disease			
Depression			
Liver disease/Hepatitis			
Migraines			
Blood vessel clots			
Lung disease			

HOSPITALIZATIONS & SURGERIES

please include dates _____

_____

MEDICATIONS

Allergies to medications? _____

Are you on any medications? _____

_____

FAMILY MEDICAL HISTORY

HAS ANYONE IN YOUR FAMILY HAD:	YES	NO	RELATIVE
High Blood Pressure			
Diabetes			
Heart Disease			
Stroke			
Alcoholism			
Osteoporosis			
Inherited genetic disease			
Cancer			
Other			

SEXUAL HISTORY	YES	NO	DETAILS
Age at first intercourse			
Are you currently sexually active			
Any pain during intercourse			
Bleeding with intercourse			
Do you practice anal sex			
Frequency of sex per week			
Have you had a new partner in the last two months?			

HABITS	YES	NO	FREQUENCY
Do you smoke cigarettes?			
Consume alcoholic beverages?			
Do you use illegal drugs?			

Date _____

Name _____
Last First Middle

LMP: _____ **EDC:** _____ **Drug Allergies** _____
(FIRST DAY OF LAST PERIOD) (OFFICE WILL FILL IN)

Birth Date	Age	Race	Marital Status S M W D SEP	Religion	Address	Phone Number

Father of Baby & Phone Number	Emergency Contact & Phone Number	Patient's Occupation & Type of Work	Highest Level of Education

OBSTETRICAL HISTORY

Total Pregnancies (INCLUDE CURRENT)	Full Term	Premature	Induced Abortion	Spontaneous Abortion (MISCARRIAGE)	Multiple Births	Living Children

PAST SIX PREGNANCIES

Delivery Date	Gest. Weeks	Birth Weight	Type of Delivery	Sex M/F	Anesthesia Yes/No	Comments/Complications	Length of Labor	Place of Delivery	Preterm Labor Yes/No

PAST MEDICAL HISTORY

	Yes	No	Detail Positive Remarks -- Include Date & Treatment
Diabetes	_____	_____	
Thyroid problems	_____	_____	
Cancer	_____	_____	
Heart Disease	_____	_____	
Breast disease/mass	_____	_____	
Stroke	_____	_____	
Anemia	_____	_____	
Bladder or Kidney disease	_____	_____	
Depression	_____	_____	
Liver disease/Hepatitis	_____	_____	
Migraines	_____	_____	
Blood vessel clots	_____	_____	
Lung disease	_____	_____	
Tobacco	_____	_____	
Alcohol	_____	_____	
Illicit Drugs	_____	_____	
Surgeries & Hospitalizations	_____	_____	

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

I. Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

II. All Claims Must be Arbitrated: It is the intention of the parties that his agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

III. Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from a civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the CCP. Discovery shall be conducted pursuant to CCP section 128.05; however, depositions may be taken without prior approval of the neutral arbitrator.

IV. General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or, (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

V. Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

VI. Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial here: _____ . This agreement is thus effective as of the date of first medical services..

VII. Severability: If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement upon request.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____
Patient or Patient Representative's Signature Date

_____
Physician's or Authorized Representative's Signature

CAP WOMEN'S HEALTH

Nikolas G. Capetanakis, D.O.
535 Encinitas Blvd, Suite 120
Encinitas, CA 92024

HIPPA - NOTICE OF PRIVACY ISSUES

Nikolas G. Capetanakis, D.O. : 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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Information
We use health information about you for treatment to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Govt. Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposed.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you r reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting are and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Privacy Officer
c/o Nikolas G. Capetanakis, D.O.
535 Encinitas, Suite 120
Encinitas, CA 92024

I acknowledge receipt of the Notice of Privacy Practices.

_____
Print name

_____
Signature

_____
Date

OFFICE POLICIES

I. CAP Women's Health: This is a private practice. Our goal is to provide you with the highest level health care. In order to maintain an efficient office and viable medical practice, we have developed the following policies. The objective of these policies is to prevent billing and patient care confusion.

II. Contracted Insurance Plans: It is your responsibility to supply us with the appropriate billing information. This includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claim. You will be required to pay any co-payment, deductible, and/or non-covered services that are considered "non-covered benefits" by your insurer. If your insurance plan does not pay your account for any reason, including a delay in billing, you will be responsible for payment of charges for your medical services. IT IS YOUR RESPONSIBILITY TO ENSURE THAT OUR OFFICE IS CONTRACTED WITH YOUR INSURANCE PLAN.

III. Private Pay: Payment is expected at the time of service. We accept payment in the form of cash, check, or Visa or MasterCard. If you are unable to pay at the time of service, you must make arrangements in advance.

IV. Returned Checks: If your check is returned, you could be liable for three (3) times the amount of the check or $100.00, whichever is more, plus face value of the check. You may be asked to pay cash for returned checks.

V. Appointment Courtesy: We realize that unforeseen circumstances might make it impossible for you to keep your appointment. If you should fail to keep an appointment without canceling at least 24 hours in advance, you will be charged **$40.00** for that failed appointment. Your insurance carrier will not cover this charge. Once payment is received in full for the missed appointment, we will be happy to reschedule another appointment. If you fail two appointments without canceling in advance, you may be dismissed from the practice and need to seek medical care from another physician. **We do not call for appointment reminders.**

VI. Medical Information: A. Medical Records: Our office will copy your medical records upon request and signing of the consent form, which authorizes the release of your records. A **$20 fee** may be charged for the copying of records. **B. Disability Forms:** A **$30 fee** will be charged for filling out any medical related employment or disability forms. This is not covered by your insurance and will be billed directly to you.

VII. Telephone Calls: We review all messages. If further consultation with a provider is desired, a fee equivalent to an office visit will be charged to you. Insurance plans do not cover telephone consultations.

VIII. On-Call Schedule: Dr. Capetanakis is a solo provider. He does his best to attend each and every birth and to be on-call for any emergent situations. However, due to unforseen circumstances, Dr. Capetanakis may not always be available. In this case, the "on-call" obstetrician/gynecologist at Scripps Memorial Hospital Encinitas will care for our patients. Occasionally he is called away from the office. We will make every effort to inform you in advance if this is necessary. Emergencies and deliveries cannot be scheduled. This is the nature of the business; we appreciate your understanding and apologize for any delays. Generally, Dr. Capetanakis does have the "on-call" physician cover the practice one weekend each month. We try our best to post these dates in advance.

IX. Laboratory: I send all laboratory specimens to West Pacific or Lab Corps unless informed otherwise. Many insurance companies require that you use a specific laboratory, radiologist, or other contracted specialist. It is your responsibility to determine which outside provider is contracted with your insurance. I cannot be responsible if you go to a lab or specialist that is not contracted with your insurance. I will direct you as best I can. When in doubt, check with your insurance company.

X. Hospital Facilities: I deliver and perform surgery at Scripps Memorial Hospital Encinitas exclusively. I will not be able to care for you at any other facility. If you present for medical care at any other hospital, you must seek another physician at the facility.

XI. Patient Care Policies: I strive to offer you excellence in both medical and personal care in an atmosphere of comfort and respect. As I respect you, I ask that you respect the staff and other patients by complying with these policies. If there is a problem please do not hesitate to speak with our office manager.

XII. Birth Announcements / Holiday Cards: Patient agrees unless expressly indicated in writing that any birth announcements or holiday cards sent to our office by you or your family are done so with the consent for those cards to be displayed by our office and patient agrees that doing so is not a HIPPA violation.

XIII. Students: We believe in the power of teaching. Occasionally we will have students in the office. Please let us know if you do not wish to have a student shadowing Dr. Cap or the Midwife during your visit. Your consent is not a condition of care.

XIV. Email: By providing your e-mail address, you expressly agree to allow communications from Cap Women's Health as well as Cap Wellness Center. We do not sell e-mail addresses. You may unsubscribe at anytime.

XV. Notice to Patients: Medical doctors are licensed and regulated by the Medical Board of California. You can find more information at (800) 633-2322 or www.mbc.ca.gov.

Signature: _____ Date: _____

Patient Name: _____

CAP WOMEN'S HEALTH