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	0969AS	A. BUILDING _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AKRON WOMEN'S MEDICAL GROUP	692 EAST MARKET STREET AKRON, OH 44305

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C 000	Initial Comments JS/DK County: Cuyahoga Administrator: Vickie Griffin, NREMT-P Type of Survey: Licensure Number of Procedure Rooms: Two The following violations were based on the licensure survey completed on 03/17/11.	C 000	2011 APR 14 A 11:30 OHIO DEPT OF HEALTH ODA-BCHCFS	
C 105	3701-83-03 (F) Liability Insurance Each HCF shall either maintain documentation of appropriate liability insurance coverage of the staff and consulting specialists or inform patients that the staff member or consulting specialist does not carry malpractice insurance. This Rule is not met as evidenced by: Based on review of staff credentialing files and staff interview and verification, the facility failed to ensure that appropriate liability insurance coverage of the staff was maintained or inform patients that the staff member did not carry malpractice insurance. One of four staff credentialing files (Staff K) was affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 the credentialing files for the facility's medical and certificated registered nurse anesthetists(CRNA) were reviewed. The facility utilized two physicians and two CRNA's for the provision of surgical services. Review of the credentialing file for Staff K,	C 105	Staff has Liability Insurance. Original Copy in Cleveland Enclosed is copy of ins which will be kept in Akron office was dated Retro 2/28/2011 See "A" 3/31/11	

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C 105	Continued From page 1 revealed there was no documented evidence the CRNA had current liability insurance. The was no documented evidence that patients were informed the CRNA did not have liability insurance. Interview of Staff A on 03/17/11, revealed that Staff K typically provided anesthesia services for the facility on surgery days. Staff A verified there was no documented evidence that Staff K had maintained current liability insurance. Staff A also verified there was no documented evidence or information that informed patients the CRNA did not have liability insurance.	C 105	CRNA HAS current Liability INSURance See "A"	3/31/11
C 122	3701-83-08 (D) Job Descriptions The HCF shall provide each staff member with a written job description delineating his or her responsibilities. This Rule is not met as evidenced by: Based on review of staff personnel files and staff interview and verification, the facility failed to provide each staff member with a written job description delineating his or her responsibilities. Four of six staff personnel files (Staff A, G, H, and J) were affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 personnel files were reviewed for staff employed by the facility. The following personnel files did not contain documented evidence of job descriptions for the duties the staff were assigned at the facility.	C 122	All job descriptions are up to date and signed in employee files	3/31/11

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C 122	Continued From page 2 1. Staff A, hired on 03/07/11, was assigned the duties of administrator of the facility. The personnel file for Staff A was incomplete. Portions of the file were faxed to the facility for review from the corporate office. Information faxed did not include the job description of administrator. 2. Staff G, hired on 06/07/10, was noted to have completed an application for recovery room nurse. The personnel file did not contain documented evidence that Staff G had received information of the job duties for a recovery room nurse. Observation of Staff G revealed he/she was working in the recovery room on 03/17/11. 3. Staff H, hired on 07/31/10, was noted to have been educated as a medical assistant. The personnel file did not contain documented evidence that Staff H had received information of the job duties for a medical assistant. Observation of Staff H revealed he/she was working in the patient reception area on 03/17/11. 4. Staff J, hired on 03/17/92, was identified by Staff A as the current director of nursing (DON) for the facility. The personnel file for Staff J contained various job descriptions for positions held since hired in 1992. The personnel file did not contain information as to when Staff J became the DON and there was no documented evidence that Staff J had received information of the job duties for the director of nursing. Staff J was not present in the facility on 03/17/11. On 03/17/11 Staff A provided a large binder labeled job descriptions. Review of the binder revealed there was no job description identified as administrator. The binder did not contain documented evidence that staff in the facility	C 122	See Administrator Job description "B" 3/31/11 See Recovery Room Job description "C" 3/31/11 See Med Asst Job descrip and Eval "D" 3/31/11 See director of Nursing "E" 3/31/11	

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C 122	Continued From page 3 were aware of the positions and job duties described in the binder. Staff A could not verify that staff were aware of specific job duties for the respective positions.	C 122	all job duties have been updated	3/31/11
C 123	3701-83-08 (E) Staff Orientation & Training Each HCF shall provide an ongoing training program for its staff. The program shall provide both orientation and continuing training to all staff members. The orientation shall be appropriate to the tasks that each staff member will be expected to perform. Continuing training shall be designed to assure appropriate skill levels are maintained and that staff are informed of changes in techniques, philosophies, goals, and similar matters. The continuing training may include attending and participating in professional meetings and seminars. This Rule is not met as evidenced by: Based on review of staff personnel files and staff interview and verification, the facility failed to provide each staff member with an ongoing training program which included orientation and continuing training to all staff members. The orientation was to be appropriate to the tasks that each staff member was expected to perform. Continuing training was to be designed to assure appropriate skill levels were maintained and that staff were informed of changes in techniques, philosophies, goals, and similar matters. Two of six staff personnel files (Staff G and H) were affected. The facility provided services for 1638 patients in 2010. Findings included:	C 123	arranged staff training ongoing Training programs has been set into practice and copies in employee files	3/31/11

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C 123	Continued From page 4 1. On 03/17/11 personnel files were reviewed for staff employed by the facility. Staff G, a registered nurse was noted to be hired on 06/07/10 and Staff H, a medical assistant was hired on 07/31/10. Both personnel files did not contain documented evidence that orientation had been provided and completed prior to assuming respective job duties. 2. Review of the personnel file for Staff H revealed a hire date of 07/31/10. The personnel file contained an employee written warning dated 12/09/10. The written warning described incorrect performance during a procedure to obtain a sample of blood from a former patient. Further review of the document revealed that proficiency testing was to have been completed prior to Staff H's work in the lab area. Staff H documented that proficiency testing had not been initially completed prior to working in the lab area but was completed on 12/08/10. Review of the action to be taken on the warning notice indicated Staff H was placed on probation. There was no documented evidence that review of facility policy and proper procedure had been completed or continuing education was to be provided. Interview of Staff A on 03/17/11 verified there was no documented evidence that further education or review of proper procedure had been provided for Staff H. 3. On 03/17/11 at 9:10 A.M., Staff A was asked to provide any in-service education provided for the staff in 2010 as well as in-services planned for 2011. Staff A indicated that all appropriate staff had been provided advanced cardiac life support (ACLS) and cardio-pulmonary resuscitation(CPR) training in 2011. There was no documented evidence of in-services provided in 2010 and no	C 123	Continuing education is now available for employes 3/31/11 Enclosed are monthly in services for employes 3/31/11	

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C 123	Continued From page 5 further training planned for staff in 2011.	C 123		
C 125	3701-83-08 (G) Staff Performance Evaluation Each HCF shall evaluate the performance of each staff member at least every twelve months. This Rule is not met as evidenced by: Based on review of staff personnel files and staff interview and verification, the facility failed to evaluate the performance of each staff member at least every twelve months. Three of six staff personnel files (Staff E, I and J) were affected. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 personnel files were reviewed for staff employed by the facility. The following personnel files did not contain documented evidence of evaluation of staff members at least every 12 months. 1. Staff E, hired on 12/10/04, was noted to have a job performance evaluation completed on 03/06/08. There was no further documented evaluation of the employee's performance. 2. Staff I, hired on 02/05/03, did not have documented evidence of evaluation of employee performance in the personnel file completed in 2010 or to date in 2011. 3. Staff J, hired on 03/17/92, was noted to have a job performance evaluation completed in April 2008. There was no further documented evaluation of the employee's performance.	C 125	Employee Evals are completed and will be done yearly they were done 3/2011 Employee eval done Employee Eval done Employee Eval done	3/31/2011 3/31/2011 3/31/2011 3/31/11

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C 125	Continued From page 6 Interview of Staff A on 03/17/11, verified the personnel files did not contain evidence that employee performance evaluations had been completed at least every 12 months for employees working in the facility longer than one year.	C 125	Employees Evals Completed	3/31/11
C 139	3701-83-10 (B) Safety & Sanitation The HCF shall be maintained in a safe and sanitary manner. This Rule is not met as evidenced by: Based on tour and observation, the facility failed to ensure that is was maintained in a safe and sanitary manner. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 between the hours of 9:30 A.M. and 10:45 A.M. tour of the facility was completed with Staff A. The following observations were noted and verified by Staff A. 1. Located in the recovery room, were nine large boxes, taped closed, labeled infectious waste. Staff A present on tour verified the boxes were filled with infectious waste that was waiting to be picked up by the contracted company. Staff A stated there was no other areas in the facility where the boxes could be stored. One patient was observed to be in the recovery room. 2. A gurney was observed in the recovery room, stored next to the boxes of infectious waste. The gurney cushion was covered with a heavy black plastic cover. The black cover was taped at the comers and was noted to have an opening	C 139	Bio hazard now has its own Room now	3/31/11

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C 139	Continued From page 7 present on the surface approximately the size of a dime. The cushion cover was frayed at the edges which allowed small pieces of foam cushion to be visibile on the cart. Staff A verified the gurney was used on surgery days when patients were brought from the procedure room to the recovery area. 3. An anesthesia machine was observed to be stored in the procedure room. Staff A verified the anesthesia machine was not used in that the facility did not provide general anesthesia. Observation of a biomedical sticker on the side of the machine revealed that it was due to be serviced in December 2010. 4. A portable suction machine on the counter in the procedure room was observed to covered with dust.	C 139	all gurneys were Reconered and will Be Reconered as needed 3/31/11 Machine maintence guy called and appt set up cleaned no dust	
C 143	3701-83-11 (A) Medical Records The HCF shall maintain a medical record for each patient that documents, in a timely manner and in accordance with acceptable standards of practice, the patient's needs and assessments, and services rendered. Each medical record shall be legible and readily accessible to staff for use in the ordinary course of treatment. This Rule is not met as evidenced by: Based on patient medical record review and staff interview and verification the facility failed to ensure that each patient's medical record was maintained in accordance with acceptable standards of practice with regard to legibility. One of the sample of patient medical records (Patient #3) was affected. The facility provided services	C 143	All medical Records See policy "F" 3/31/11	

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C 143	Continued From page 8 for 1638 patients in 2010. Findings included: On 03/17/11 review of Patient #3 medical record was completed. Upon entrance, Staff A was asked to provide the medical records of any patients who were transferred to a hospital directly from the facility. The medical record for Patient #3 was provided. Review of the medical record for Patient #3 revealed the patient was admitted to the facility for a surgical procedure on 02/04/11. Review of the anesthesia record revealed the surgery began at 2:29 P.M. and was stopped at 2:50 P.M. The patient was noted to have been sent by ambulance to a local hospital. Review of the written operative report completed by the physician, revealed the writing was mostly illegible. Few words could be determined in the hand written note that could indicate what had occurred with the patient during the operative procedure. It was determined that patient was transferred to the hospital due to an unusually large amount of bleeding. Staff A reviewed and verified the physician's documentation was mostly illegible and a complete account of the operative procedure could not be determined.	C 143	All records of pt going to hospital shall be kept in Directors office 3/31/11	
C 152	3701-83-12 (C) Q A & Improvement Requirements The quality assessment and improvement program shall do all of the following: (1) Monitor and evaluate all aspects of care	C 152		

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C 152	Continued From page 9 including effectiveness, appropriateness, accessibility, continuity, efficiency, patient outcome, and patient satisfaction; (2) Establish expectations, develop plans, and implement procedures to assess and improve the quality of care and resolve identified problems; (3) Establish expectations, develop plans, and implement procedures to assess and improve the health care facility's governance, management, clinical and support processes; (4) Establish information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality improvement, and to comply with the applicable data collection requirements of Chapter 3701-83 of the Administrative Code; (5) Document and report the status of quality assessment and improvement program to the governing body every twelve months; (6) Document and review all unexpected complications and adverse events, whether serious injury or death, that arise during an operation or procedure; and (7) Hold regular meetings, chaired by the medical director of the HCF or designee, as necessary, but at least within sixty days after a serious injury or death, to review all deaths and serious injuries and report findings. Any pattern that might indicate a problem shall be investigated and remedied, if necessary. This Rule is not met as evidenced by: Based on review of the facility quality	C 152	Had Board of directors meeting 3/31/11 3/31/11 QA plan is now up to date 3/31/11 will have a meeting w medical director	

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C 152	Continued From page 10 improvement program and review of governing body meeting minutes the facility failed to ensure that a report of the status of the quality assessment and improvement program was provided to the governing body every twelve months. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 review of the facility's quality assurance program and governing body meeting minutes was completed. Documentation of the of the quality improvement (QI) program revealed the facility had a program but no documented evidence of ongoing QI projects. There was no documented evidence of QI meetings held in 2010 and to date in 2011. Review of governing body meeting minutes revealed the last documented governing body meeting was held on January 31, 2010. Interview of Staff A revealed there was no documentation of QI projects available for review. Staff A further verified the last documented governing body meeting was completed in 2010 with no documented evidence that QI information was presented at the meeting.	C 152	meeting held 3/31/11 by board of directors 3/31/11	
C201	3710-83-16 (B) Governing Body Duties The governing body shall: (1) At least every twenty-four months review, update, and approve the surgical procedures that may be performed at the center and maintain an up-to-date listing of these procedures;	C201	all Physicians are credentialed and procedures approved	

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C201	Continued From page 11 (2) Grant or deny clinical (medical-surgical and anesthesia) privileges, in writing and reviewed or re-approved at least every twenty-four months, to physicians and other appropriately licensed or certified health care professionals based on documented professional peer advice and on recommendations from appropriate professional staff. These actions shall be consistent with applicable law and based on documented evidence of the following: (a) Current licensure and certification, if applicable; (b) Relevant education, training, and experience; and (c) Competence in performance of the procedures for which privileges are requested, as indicated in part by relevant findings of quality assessment and improvement activities and other reasonable indicators of current competency. (3) In the case of an ASF owned and operated by a single individual, provide for an external peer review by an unrelated person not otherwise affiliated or associated with the individual. The external peer review shall consist of a quarterly audit of a random sample of surgical cases. This Rule is not met as evidenced by: Based on review of physician credentialing information and staff interview and verification, the facility failed to ensure that a review, update and approval of the surgical procedures that may be performed at the center were maintained in an up-to-date listing of the procedures for the physician's who requested clinical privileges. Two of two physician files were affected. The facility provided services for 1638 patients in 2010.	C201	All Physicians and CRNA Credentialing are up to date 5/31/11	

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C201	Continued From page 12 Findings included: On 03/17/11 review of the physician credentialing files was completed. The facility utilized two physicians for the provision of surgical services. Review of both physician credentialing files revealed there was no delineation of requested procedures. The files did not contain an updated list of the procedures requested by the physicians to be performed in the facility, no review and no approval date for procedures currently performed by the physicians. Staff A verified the credentialing files for the physicians did not contain an updated list of requested and approved procedures performed in the facility.	C201	Approved Procedures are in physicians files 3/31/11	
C243	3701-83-20 (D) Ventilation & Humidity Levels Each ASF shall have appropriate ventilation and humidity levels in order to minimize the risk of infection and to provide for the safety of the patient. This Rule is not met as evidenced by: Based on tour of the facility, review of facility information and staff interview and verification, the facility failed to ensure appropriate ventilation and humidity levels were maintenance in order to minimize the risk of infection and to provide for the safety of the patients. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 tour of the facility was completed between 9:30 A.M. and 10:45 A.M. with Staff A.	C243		

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C243	Continued From page 13 The facility was noted to be on two floors. The main floor was the reception area, counseling areas and a large waiting area for patients and others. The lower level of the facility contained the procedure rooms, recovery area, instrument processing areas, small lab area and a small waiting area. Review of the facility's temperature and humidity logs revealed the temperature and humidity levels were monitored only for the main level of the facility. There was no documented monitoring of humidity levels for the lower level of the facility since May 2010. Interview of Staff A verified that instruments to monitor the humidity were kept on the main level of the facility. Staff A verified the humidity level for the procedure and recovery areas had not been monitored for some time.	C243	We now have Temp & Humidity for both floors 3/31/11	
C244	3701-83-20 (E) Emergency Power Each ASF shall have emergency power available in operative and recovery areas. This Rule is not met as evidenced by: Based on facility tour and staff interview and verification, the facility failed to ensure that emergency power was available in operative and recovery areas. The facility provided services for 1638 patients in 2010. Findings included: On 03/17/11 tour of the facility was completed between 9:30 A.M. and 10:45 A.M. with Staff A. The facility was noted to be on two floors. The	C244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0969AS	A. BUILDING _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AKRON WOMEN'S MEDICAL GROUP	692 EAST MARKET STREET AKRON, OH 44305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C244	Continued From page 14 lower level of the facility contained the procedure rooms, recovery area, instrument processing areas, small lab area and a small waiting area. Interview of Staff A revealed there was no emergency power provided for the procedure or recovery areas. At 4:30 P.M. Staff A indicated the facility did have emergency power available to the ares in the form of a battery pack. Staff A could not provide documentation of preventative maintenance and testing information to verify the emergency power pack was operable.	C244	Preventive Maintenance and log are now in effect 5/31/11	

THE AKRON WOMANS MEDICAL GROUP

EMPLOYEE JOB DESCRIPTION

I. JOB TITLE: **Associate Administrator**

II. QUALIFICATIONS: Associates or Bachelors degree, preferably in the Medical field or Social Services. Experience in management of a social agency or a medical facility. Experience in the field of reproductive health, particularly family planning and abortion services.

III. RESPONSIBLE TO: Executive Director

IV. RESPONSIBILITIES:

A. Maintain referral statistics.

1. Abortion and State Statistics on a monthly basis
2. Maintain accurate listing of referral resources

B. Manage clinic operations on Saturday's and in the absence of the Executive Director.

C. Revise and update policy and procedures as directed by the Executive Director.

1. Procedure manual
2. Counseling protocols and procedures.
3. OSHA manuals.
4. HIPPA policy and procedure.
5. Notes from all staff meetings.
6. CLIA manual and inspections.
7. State of Ohio inspections.

"B"

D. Act as liaison for indigent woman seeking financial assistance for abortions.

E. Oversee schedule for employees

F. Coordinate scheduling of private patients of staff physicians.

G. Responsible for ordering and maintaining supply of brochures, appointment cards, etc.

H. Revise and prepare changes in printed materials as directed by the Executive Director.

V. COUNSELING: Maintain and supervise the counseling staff.

1. With the help of other counselors train and orient new counselors.
2. Act as reject/discharge counselor for undecided Patients per clinic schedule.
3. Fill in for counseling staff as needed.

I have read the above duties and responsibilities and agree to perform them as directed.

NAME: _____ **DATE:**_____

WITNESS:_____

AKRON WOMEN'S MEDICAL GROUP

EMPLOYEE JOB DESCRIPTION

I. Job Title: **Recovery Room R.N./LPN**

II Job description: To provide competent, professional and skilled nursing care to recovery room patients.
To meet the physical and emotional needs of these patients in a confidential environment.

III. Qualifications: The Recovery Room Nursing Staff may consist of Registered Nurses, as well as Licensed Practical Nurses who are currently licensed by the state of Ohio. Their professional backgrounds should include Recovery Room Nursing or other PACU or Post-op nursing.

IV. Staffing Levels The Nurse/patient ratio should be appropriate and adequate with regard to the anesthesia used. General anesthesia and second trimester patients require one nurse of every three patients. First trimester patients require one nurse for every four- (4) patients.

V. Procedure Check supplies in medicine cabinet and refrigerator; particular attention is given to expiration dates of medications, and inventory levels. The R.R. nurse is responsible for the emergency cart. The oxygen tanks must be checked daily.

The work area must be kept clean at all times, and the area checklist must be completed at the end of every clinic day.

Immediately upon patient admission, the R.R. nurse charts:

A. Time of admission
B. Vitals including; B/P, pulse, respiration's.
C. Bleeding; (scant, moderate, or large)
D. Pulse ox if necessary

DO NOT leave patient bedside until patient's condition is stable and patient is responsive.

SIDE RAILS MUST BE UP ON ALL PATIENTS.

Review patient chart; check MD's orders, chart results of physical assessment.

Repeat patient assessment at 15-minute intervals, then at 30-minute intervals, more frequently if condition warrants. Chart all findings in nurse's notes, record all medication administered or dispensed.

The nurse continues to make the patient as comfortable as possible and answer any questions that may arise during the recovery period.

Stimulate patient frequently. General anesthesia patients must be encouraged to deep breathe to remain awake.

All IV's must be monitored, added to and discontinued as indicated.

In the event of an emergency or the development of any abnormal symptoms, the nurse must take appropriate action and simultaneously notify the doctor. Report immediately and change in vital signs, bleeding or any other problem so that immediate action can be taken.

A thorough knowledge of emergency procedure is mandatory.

VI. DISCHARGE

Patients receiving only local anesthesia may be discharged after 20 minutes. Those receiving IV sedation may be discharged after 30 minutes if vital signs are stable, bleeding is normal, and the patient is in on apparent distress.

Patients receiving a general anesthesia are to remain a minimum of 45 minutes. When the patient is alert and vital signs are stable, she may sit up. Assist the patient to the discharge area and dressing rooms. All patients who have had any type of sedation are to leave the facility via the elevator.

PATIENT DISCHARGE PACKET MUST INCLUDE:

a. A prescription for ergotrate 0.2 mcg to be taken QID (#12) if the physician prescribes this medication.
b. Doxycycline 500mg. PO BID until gone if physician prescribes.
c. Cytotec 400 Mcg buccally q4hrs if physician prescribes.
d. Oral contraceptives, as prescribed by the physician or other contraceptive instructions.
e. Post-op instruction sheet.

The nurse based on the patient's physical and emotional condition makes discharge decision. Time of discharge must be charted on the recovery room sheet.

At the end of the day, all medications are to be counted and all accounted for by two RN's. They must then be locked in the medicine cabinet. Used needles and syringes are to be put in proper disposal units. Clean all mattresses and pillows with the proper disinfectant.

Restock supplies; report needed supplies to the nursing supervisor indicating the data and the amount on hand. Turn off the lights and check the air conditioner/furnace thermostat.

I have read the above duties and responsibilities and agree to perform them as directed.

NAME:_____ DATE:_____

WITNESS:_____

AKRON WOMEN'S MEDICAL GROUP
EMPLOYEE JOB DESCRIPTION

I. JOB TITLE:

Medical Assistant/O.R. Room tech

II. QUALIFICATIONS:

Needs a broad base of experience in general Hospital or Surgery Center procedures with knowledge of basic nursing procedures and terminology. Must have current CPR card. Special qualifications should include a pleasing personality, the ability to establish patient rapport, and the ability to display a supportive attitude towards patients. Emergency Room and previous surgery experience and/or knowledge of OB/GYN experience and/or knowledge of OB/GYN techniques and terminology are desirable. Can be trained by physician on duty.

III. RESPONSIBLE TO:

The Director of Nursing and Medical Director

IV. RESPONSIBILITIES:

- **A.** To provide basic, direct care of patients and patient flow in the center.
- **B.** Generally assisting patients during their visit with the facility.
- **C.** Assist nurses with obtaining patient's vital signs.
- **D.** Informing the nurses and/or medical director of any complications with a patient.
- **E.** Be sure that all patients' area treated in a kind professional manner.
- **F.** To dispose of all trash in plastic bags or Biohazard bags.
- **G.** Assist with cleaning and maintaining instruments and/or supplies.
- **H.** Inventory supplies in the morning and request needed supplies from Ordering Clerk.
- **I.** Maintain the appearance of the supply closets and put supplies in their proper order when they arrive.
- **J.** Wear scrub clothes when procedures are in progress.
- **K.** Other jobs as deemed necessary by the Director of Nursing.

I have read the above duties and responsibilities and agree to perform them as directed.

NAME:_____ **DATE:**_____

WITNESS:_____

"D"

AKRON WOMEN'S MEDICAL GROUP
Employee Job Evaluation
Medical Assistant/ O.R. Room Tech

Employee Name:_____

Employee knows how to obtain patient vital signs._____

Employee knows how to inform nurses/doctor of any complications with patient._____

Employee knows how to dispose of all trash in plastic bags or Biohazard bags._____

Employee knows how to clean and maintain instruments and/or supplies._____

Employee knows how to document the inventory of supplies._____

Employee knows how to stock supplies and maintain the appearance of the supply closets._____

Employee knows how to take appropriate action in case a patient is experiencing an emergency._____

Employee knows what to do in case of fire or emergency._____

Employee understands and is able to perform the above duties

EMPLOYEE SIGNATURE_____

PRINT NAME_____

EMPLOYEE EDUCATOR SIGNATURE _____

DATE_____

THE AKRON WOMEN'S MEDICAL GROUP

EMPLOYEE JOB DESCRIPTIONS

I. JOB TITLES: **DIRECTOR OF NURSING**

II. JOB DESCRIPTION:

Responsible for the maintenance of high standards of care for all the services to patients at the clinic. To direct and supervise and train members of nursing staff according to the policies and procedures of the clinic. To supervise the medical assistants in the laboratory. Responsible for coordinating the activities or services with the policies of the clinic and ensuring those proper standards of quality and care are maintained.

III. RESPONSIBLE TO: The executive Director and the Medical Director

IV. QUALIFICATIONS:

A. Shall be a RN currently licensed to practice in the State of Ohio.

B. Shall be experienced in OR and Recovery Room techniques. Shall hold a certified CPR rescuer card. Should have some type of supervisory experience with administrative skills. Family planning training and OB-GYN training would be helpful. Should also be certified in ACLS.

C. It is necessary that the administrative assistant in charge of service possess knowledge of the functioning, aims and activities of the Akron Women's Medical Group. She should be committed to the principles of family planning and the right of each to control their fertility. Also, her personality should allow harmonious working with all staff members to direct and produce maximum efficiency of the staff.

V. DUTIES:

A. To check emergency equipment each morning that procedures are being done.

B. To direct the nursing team and operating procedures when procedures are to be performed at The Akron Women's Medical Group.

C. To provide and schedule adequate nursing personnel.

D. In charge of complaint calls and follow through on dispositions ensuring that notes are added to patient records, return necessary calls.

Must maintain a record of all patient complaint calls.

E. To handle all patient calls received during surgical days when on the premises. After hour the nurse or physician on call will handle calls.

F. To follow up on all abnormal lab reports.

G. To inspect daily and insure each department is equipped, organized, clean, and prepared in order to insure aseptic technique, provide safe and adequate care to all patients, and maintain efficient functioning of each department.

H. To help insure that the OR log is maintained and correct on all procedures.

I. Responsible for appearances, supervision, and teamwork of the staff for all services.

J. To evaluate staff and submit forms to the executive director on a yearly basis, reflecting the hire date.

K. To conduct in-service training for the staff.

L. To insure all patients records are in order to maintain the accuracy of those records.

M. To orient and supervise students.

N. To provide patient education in conjunction with the counselor.

O. To be sure that all state licensing requirements are met as far as nursing care is concerned.

P. To be sure that all licenses are up to date.

Q. To do all N.A.F. statistics.

R. To keep accurate medical files on all employees. Giving yearly TB and Hepatitis reviews.

S. To schedule all medical staffing on a weekly basis with copy of schedule to the Executive Director.

I have read the above duties and responsibilities and agree to perform them as directed.

NAME: _____DATE:_____

WITNESS:_____

E

AKRON WOMEN'S MEDICAL GROUP		
ORIGINAL DATE: MARCH 31, 2011	REVISED DATE:	PAGE NUMBER: 1 OF 1
POLICY NUMBER: 07-05	SUBJECT: LEGIBILITY OF HANDWRITING	

POLICY

HANDWRITING LEGIBILITY

All medical charts shall have legible handwriting on all parts of the patient record. If there is a physician or nurse who is not able to write legible then the chart shall be dictated to someone on staff that can legibly write and signed by the physician who handled the patient.

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44304
1-800-428-3673

STATE AMBULATORY SURGERY CENTER LICENSE 0969AS

ADDENDUM PER PHONE CONVERSATION WITH LINDA HEART ON 4/21/2011

ID PREFIX TAG #	REPLY
122	THE ASSOCIATE ADMINISTRATOR VICKI GRIFFIN ALONG WITH THE DIRECTOR OF NURSING BRENDA HARLESS WILL MONITOR JOB DESCRIPTIONS.
123	MONTHLY CONTINUING EDUCATION WILL BE GIVEN TO EVERY EMPLOYEE. A QUIZ WILL BE ADMINISTERED AND GIVEN TO THE EMPLOYEE . THE RESULTS WILL BE PUT IN THEIR EMPLOYEE CHART. THIS WILL BE MONITORED BY THE ASSOCIATE ADMINISTRATOR VICKI GRIFFIN AND THE DIRECTOR OF NURSING BRENDA HARLESS. ALL NEW EMPLOYEES SHALL HAVE JOB TRAINING IN THE AREA IN WHICH THEY WERE HIRED.
125	THE ASSOCIATE ADMINISTRATOR VICKI GRIFFIN AND THE DIRECTOR OF NURSING BRENDA HARLESS SHALL MONITOR ALL EMPLOYEE EVALUATIONS SO THAT THEY ARE DONE IN A TIMELY MANNER.
139	THE DIRECTOR OF NURSING BRENDA HARLESS SHALL MONITOR THE CHANGING OF THE GURNEY COVERS. SEE EXAMPLE "A". ALL MEDICAL EQUIPMENT SHALL BE CLEANED MONTHLY AND THIS WILL BE MONITORED BY THE DIRECTOR OF NURSING BRENDA HARLESS. SEE EXAMPLE "B". ALL SHALL BE MONITORED BY A MONTHLY LOG.
143	THE PLAN OF CORRECTION FOR LEGIBILITY OF HANDWRITING IS AS FOLLOWS: ALL MEDICAL CHARTS SHALL HAVE LEGIBLE HANDWRITING ON ALL PARTS OF THE PATIENT RECORD. IF THE PHYSICIAN OR A NURSE IS UNABLE TO WRITE LEGIBLY THEN THE CHART SHALL BE DICTATED TO THE DIRECTOR OF NURSING BRENDA HARLESS TO WRITE IN A LEGIBLE MANNER AND SIGNED BY THE PHYSICIAN WHO DID THE PATIENTS PROCEDURE. ALL PROBLEM CHARTS SHALL BE PUT IN A RED FOLDER AND KEPT IN THE ASSOCIATE DIRECTORS OFFICE WHERE THE CHART SHALL BE

	RELIABLY AVAILABLE. THE ASSOCIATE DIRECTOR VICKI GRIFFIN SHALL MONITOR THAT HOSPITAL RECORDS ARE AVAILABLE TO ALL STAFF.
152	THE BOARD OF DIRECTORS MEETING WAS HELD ON 03/31/2011. ENCLOSED IS COPY OF THE MEETING. THE DIRECTOR OF NURSING BRENDA HARLESS WILL MONITOR THE CREDENTIALING OF ALL PHYSICIANS AND NURSES AND BE SURE THEY ARE UP TO DATE.
243	THERE IS A NEW TEMPERATURE AND HUMIDITY MONITOR IN THE DOWNSTAIRS. ENCLOSED IS THE LOG EXAMPLE "D" WHICH WILL BE MONITORED BY THE DIRECTOR OF NURSING BRENDA HARLESS.
244	PREVENTATIVE MAINTENANCE ON THE BATTERY BACK-UP GENERATOR SHALL HAVE PREVENTATIVE MAINTENANCE DONE ON IT SEMI-ANNUALLY BY THE MAXIM COMPANY. ANY MACHINE THAT DOES NOT PASS THE PREVENTATIVE MAINTENANCE TESTS, SHALL BE TAKEN OUT OF CIRCULATION AND USE UNTIL IT CAN BE REPLACED OR SERVICED. THIS SHALL BE MONITORED BY THE DIRECTOR OF NURSING BRENDA HARLESS. ALSO, THERE IS A LOG TO MONITOR THAT THE MACHINE IS WORKING PROPERLY. EXAMPLE "E".

ENCLOSED ARE EXAMPLES "A" THROUGH "E". IF THERE ARE ANY QUESTIONS PLEASE CALL ME AT OUR OFFICE AT 1-800-428-3673.

THANK YOU

BRENDA HARLESS, RN, DON

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44304
1-800-428-3673

MONTHLY GURNEY COVER CHANGING LOG

MONTH	# GURNEY COVERS CHANGED	SIGNATURE
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44304
1-800-428-3673

MONTHLY EQUPIMENT CLEANING LOG

MONTH	ALL MEDICAL EQUIPMENT CLEANED AND DUSTED	SIGNATURE
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

"B"

AKRON WOMEN'S MEDICAL GROUP
EXECUTIVE COMMITTEE MEETING
FRIDAY MARCH 31, 2011
9:00 A.M.---EXECUTIVE DIRECTORS OFFICE

I. Meeting called to order by Director — Carol Westfall, Executive

II. Approval of staff meeting minutes by Director — Carol Westfall, Executive

III. Report by the President — Gerald Grossman, President

a. Financial planning for year 2011
b. Financial budget review for payroll, need to decrease payroll costs.
c. Review patient equipment and get quotes to replace old equipment.
d. Get quotes for new copier. It is getting too time consuming to continue making
Copies in the Cleveland office and having them transported to Akron.
e. Review budget for 692 East Market and see where cuts can be made.

IV. Administrative Report — Gerald Grossman, Carol Westfall

a. State Recertification for ASC license. Deficiencies are to be fixed and sent to State.
b. To continue to monitor State and Local level legislation pertaining to Abortions. Monitor web sites and State representatives for any changes.
c. Malpractice insurance has been renewed thru ACORD insurance. Liability will include all physicians and CRNA's.
d. Moving of Biohazard waste and Laundry to second floor room due to sanitary issues with the State of Ohio.
e. Continue working with local police departments on the protestor problem that the clinic has been having with extreme right to life protestors.

f. Review safety policies with the staff and maintain the Security people on patient clinic days.

V. Medical Records Reviewed by

M.H. Rezaee
Gerald Grossman
Carol Westfall
Brenda Harless

The above people reviewed twenty (20) medical records for Quality Assurance and found them to be free of errors.

VI. Bylaws, Rules and regulations recommendations by:

Carol Westfall
Gerald Grossman

VII. Meeting Adjourned @ 11:15am.

Gerald Grossman, President — 3/31/11 — 03/31/2011

M. H. Rezaee, MD, Medical Director — 3/31/11 — 03/31/2011

Carol Westfall, Executive Director, Secretary — 3/31/11 — 03/31/2011

AKRON WOMEN'S MEDICAL GROUP

DOWNSTAIRS TEMPERATURE LOG

TEMPERATURE MUST BE BETWEEN 66-75^{0}F

HUMIDITY MUST BE BELOW 65%

DATE	TEMPERATURE	HUMIDITY	INITIALS

AKRON WOMEN'S MEDICAL GROUP

BATTERY BACK-UP GENERATOR LOG

DATE	GREEN LIGHT ON	PLAN OF CORRECTION	INITIALS

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
0969AS	AKRON WOMEN'S MEDICAL GROUP

Type of Survey (select all that apply)

2

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 03180	03/17/2011	03/17/2011	0.50	0.00	9.00	0.00	2.50	0.50
2. 03171	03/17/2011	03/17/2011	0.25	0.00	9.00	0.00	2.25	0.25
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 1.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("AGREEMENT") is hereby entered into by and between Summa Health System Hospitals ("SHSH") with its principle place of business at 525 East Market Street, Akron, Ohio 44309 and Akron Surgi-Center, Inc. dba Akron Woman's Medical Group ("CENTER") located at 839 East Market Street, Akron, Ohio 44305.

RECITALS

A. SHSH is a non-profit Ohio corporation that operates Akron City Hospital and Saint Thomas Hospital and provides access to patient care for the residents of its service area; and

B. CENTER is an institution established for the purpose of providing patient care and ambulatory surgical services for the residents of its service area; and

C. CENTER and SHSH mutually agree that any prior Patient Transfer Agreements/Transfer Agreements for the movement of patients between Akron City Hospital and CENTER and/or Saint Thomas Medical Center and CENTER and/or SHSH and CENTER are hereby terminated; and

D. CENTER and SHSH have determined that it is in the best interest of patient care and it would promote the optimum use of the respective parties' facilities to enter into a Patient Transfer Agreement for the transfer of ambulatory surgical patients from CENTER to SHSH in the event that such patients require hospital services.

NOW, THEREFORE, in consideration of the mutual covenants, promises and agreements herein contained, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, CENTER and SHSH agree as follows:

1. Term:

This Agreement shall commence on January 1, 2000 and shall continue until terminated pursuant to the terms hereof.

SUMMA
Health System

Akron City Hospital
525 East Market St.
P.O. Box 2090
Akron, OH 44309-2090

St. Thomas Hospital
444 North Main St.
P.O. Box 2090
Akron, OH 44309-2090

Phone (330) 375-3000

Fax Cover Sheet

Date: 2-24-2007 **Pages:** 9

To: Brenda Hackess **From:** Debbie Cochran

Co/Dept: **Dept:** Risk Management

Phone: 330-535-9191 **Phone:** 330-375-3105 996 8824

Fax: 330-535-9925 **Fax:** 330-375-4036

Re: Transfer Agreement **CC:**

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Proof

Comments:

COPY

2. Purpose of the Agreement:

CENTER agrees to transfer to SHSH and SHSH agrees to receive from the CENTER patients in need of hospital care.

3. Patient Transfer:

The need for transfer of a patient from the CENTER to SHSH shall be determined by the patient's attending physician in consultation with a physician from the receiving institution. SHSH agrees to admit the patient as promptly as possible, provided that all conditions of eligibility for admission are met and bed space is available to accommodate that patient. Prior to moving the patient, the transferring institution must receive confirmation from the receiving institution that it can accept the patient.

4. Provision of Information to Each Institution:

Each institution shall provide the other institution with the names or classifications of persons authorized to initiate, confirm and accept the transfer of patients on behalf of the receiving institution. The institutions agree to provide each other with information about the type of resources available and the types of patients and health conditions that the receiving institution will accept.

5. Patient Records and Personal Effects:

Each of the institutions agrees to adopt standard forms for medical and administrative information to accompany the patient from one institution to the other. The information shall include, when appropriate, the following:

A. Patient's name, address, hospital number, age; and name, address and telephone number of the next of kin.

B. Patient's Advance Directives.

C. Patient's third party billing information.

D. History of the injury or illness.

E. Condition at admission.

F. Vital signs including pre-hospital glasgow coma, during stay in the Emergency Department, and the time of transfer.

G. Initial diagnostic impression.

H. Treatment provided to the patient, including medications given and route of administration.

I. Laboratory and x-ray findings, laboratory specimens, and all x-ray films.

J. Fluids given, by type and volume.

K. Name, address, and phone number of physician referring patient.

L. Name of physician in receiving institution to whom patient is to be transferred.

M. Name of physician at receiving institution who has been contacted about patient.

N. Identification of the patient as a Medicare Part A beneficiary of a skilled nursing facility, if applicable.

Each institution agrees to supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving institution. In addition, each institution agrees to adopt a standard form to inventory a patient's personal effects and valuables that shall accompany the patient during transfer. The records described above shall be placed in the custody of the person in charge of the transporting medium who shall sign a receipt for the medical records and the patient's valuables and personal effects and in turn shall obtain a receipt from the receiving institution when it receives the records and the patient's valuables and personal effects.

6. Transfer Consent:

The transferring institution shall have the responsibility for obtaining the patient's consent to the transfer to the other institution prior to the transfer. If the patient is not competent, the transferring institution shall obtain a family member's consent; if such consent is not possible, the consent of the patient's physician shall be obtained by the transferring institution.

7. Payment for Services:

The patient is primarily responsible for payment for care received at either institution and, prior to transfer, the patient should be required, if competent, to acknowledge the obligation to pay for such care at the receiving institution. Each institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either institution to look to the other institution to pay for services rendered to a patient transferred by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

Nothing in this Agreement shall be construed as an offer or payment by one party to the other party (or any affiliate of either party) of any remuneration for patient referrals, or for recommending or arranging for the purchase, lease, or order of any item or service for which payment may be made in whole or in party by Medicare or Medicaid. Any payment made by either party to the other is intended to represent the fair market value of the supplies and/or services to be rendered by the respective party hereunder and are not in any way related to or dependent upon referrals by and between the parties. Furthermore, it is the stated intent of both parties that nothing contained in this Agreement is or shall be construed to be an endorsement for any act of either party.

8. Transportation of Patient:

The transferring physician, in consultation with the receiving physician, shall have responsibility for arranging transportation of the patient to the other institution, including selection of the mode of transportation and providing appropriate health care practitioners to accompany the patient. The receiving institution's responsibility for the patient's care shall begin when the patient is admitted, either as an inpatient or an outpatient, to that institution.

9. Advertising and Public Relations:

Neither institution shall use the name of the other institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the party whose name is to be used. Both institutions shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each institution shall maintain good public and patient relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

10. Independent Contractor Status:

Both institutions are independent contractors. Neither institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either institution, nor shall it in any way alter the control of the management, assets, and affairs of the respective institutions. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

11. Liability:

Each institution shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other institution.

12. Insurance:

SHSH shall secure and maintain or cause to be secured and maintained, with respect to SHSH, during the term of this Agreement, comprehensive, general and professional

liability insurance, and property damage insurance or SHSH shall self insure in an amount adequate to protect SHSH in carrying out its duties and responsibilities in accordance with this Agreement.

CENTER shall secure and maintain, or cause to be secured and maintained, with respect to CENTER during the term of this Agreement, comprehensive, general and professional liability insurance, and property damage insurance providing minimum limits of liability adequate to protect CENTER in carrying out its duties and responsibilities pursuant to this Agreement. If SHSH so requests, CENTER shall provide SHSH with evidence of such insurance coverage.

13. Termination:

This Agreement may be terminated by either party by providing thirty (30) days written notice of its intention to terminate to the other party.

14. Non-Waiver:

No waiver of any term or condition of this Agreement by either party shall be deemed or a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

15. Governing Law:

This Agreement shall be interpreted and enforced in accordance with the laws of the State of Ohio.

16. Assignment:

This Agreement shall not be assigned in whole or in part by either party without the prior written consent of the other party.

17. Invalid Provision:

In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

18. Amendment:

This Agreement may be amended at any time by a written agreement signed by the parties hereto.

19. Notice:

Any notice required or allowed to be given hereunder shall be deemed to have been given upon deposit in the United States mail, registered or certified, with return receipt requested and addressed to the party to this Agreement to whom notice is given.

20. Entire Agreement:

This Agreement constitutes the entire Agreement between the parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the subject matter hereof.

21. Binding Agreement:

This Agreement shall be binding upon the successors or assigns of the parties hereto.

22. Non-Exclusivity:

This Agreement is non-exclusive. The parties to this Agreement reserve the right to enter into similar agreements with other institutions.

23. Third Party Beneficiary:

The parties do not intend that individuals receiving services pursuant to this Agreement occupy the position of third party beneficiary to the Agreement.

24. Headings:

The headings of the various sections of this Agreement have been inserted for convenience only and shall not modify, define, limit or expand express provisions of this Agreement.

25. Non-discrimination:

Both parties agree to comply with all applicable Federal and State laws prohibiting discrimination against persons on account of race, sex, color, age,

religion, national origin or disability.

26. Debarment Certification:

Each party hereby represents and warrants the following:

A. That it has not been debarred, excluded, suspended or otherwise determined to be ineligible to participate in federal health care programs (collectively, "Debarment" or "Debarred", as applicable); and

B. That it shall not knowingly employ or contract with, with or without compensation, any individual or entity (singularly or collectively, "Agent") listed by a federal agency as Debarred. To comply with this provision, each party shall make reasonable inquiry into the status of any Agent contracted or arranged by it to fulfill the terms of this Agreement by reviewing, at a minimum, the Health and Human Services - Office of Inspector General Cumulative Sanctions Report (www.dhhs.gov/progorg/oig) and the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs (www.arnet.gov/epls), which internet sites may be revised from time to time by the U. S. government.

In the event that either party and/or its Agent either 1) becomes Debarred or 2) receives notice of action or threat of action with respect to its Debarment during the term of this Agreement, each party agrees to notify the other immediately. In the event that either party or its Agent becomes Debarred as set forth above, this Agreement relative to such Debarred entity or individual's participation hereunder shall automatically terminate upon receipt of such notice without any further action or notice; and

Each party agrees to act in compliance with all laws and regulations (including without limitation, Medicare and Medicaid program requirements as applicable) which relate to its performance of this Agreement. Each party agrees to timely notify the other in the

of such violation, to enable non-violating party to take prompt corrective action. Each party agrees that the other shall have the right to automatically terminate this Agreement in the event that the other party fails to comply with this provision.

IN WITNESS WHEREOF, CENTER and SHSH have executed this Agreement below.

WITNESSES:

Susanne Y. Martin

Stan Merritt

Linda Bryan

Brenda Barbee

SHSH

By: Linda Breedlove

Its: Adm. Director, ED/Trauma Svcs

CENTER

By: Norman E. Matthews, M.D.

Its: Medical Director

H:\LEGAL\hosptransfer agr\akronsurgicenter 02/03/00

OHIO DEPARTMENT OF HEALTH
DIVISION OF QUALITY ASSURANCE
BUREAU OF COMMUNITY HEALTH CARE FACILITIES
NON LONG TERM CARE QUALITY UNIT

FACILITY INFORMATION DOCUMENT

Facility Name	Akron Woman's Medical Group				NPI
Address	692 E. Market Street				
City/County	Akron Summit				Zip +4: 44304
Mailing Address	692 E. Market Street				
City/County	Akron Summit				Zip +4: 44304
E-Mail Address					
Administrator Name	Vickie L. Griffin Associate Administrator				
	Number:	Type:	Eff. Date:	Exp. Date:	Date Began Employment With Facility:
					March 7, 2011
Other Information	Telephone: (330) 535-9191 Fax: (330) 535-9925				
	Provider No.: Licensure No.: 0969AS Medicaid No.:				
	FISCAL INTERMEDIARY/CARRIER: Name/Address/Phone #				
	NA				

Facility Type: ☒ ASC ☐ CAH ☐ CORF ☐ ESRD ☐ HHA ☐ HOSPICE ☐ PPS ☐ PTIP
☐ REHAB ☐ RURAL H ☐ X-RAY ☐ MLP ☐ HOSP ☐ HCS

ACCREDITED: ☐ Yes ☒ No Maternity Lic Exp Date _____

Fiscal Year 12-31-11

Action: ☐ Certification ☒ Licensure ☐ PCR/PSR ☐ Complaint No. _____ ☐ Other: _____

FACILITY BEDS:	Total	Hospital	Hospice	PPS Psych	PPS Rehab	Maternal Beds	N/B
Total Beds							
Total Census							

HEALTH SURVEYS:

Survey Entry Date:	Entrance Time: A.M. P.M.
Day of the Week: M T W Th F Sat Sun	
Week of the Month: 1 2 3 4	
Survey Exit Date:	Exit Time: A.M. P.M.

LSC SURVEYS:

Survey Entry Date:	Entrance Time: A.M. P.M.
Number of Buildings:	Description of Construction Type:
Construction Dates (each bldg.):	
Survey Exit Date:	Exit Time: A.M. P.M.

☐ Additional Information On Back

Completed By: Jean Crowder	Date: 3-17-11

Fac info doc NLTC revised 5 03/31/09

POC REVIEW

Provider Name: Akron Womens Med Group CCN: 0969AS

Facility Phone #: 330-535-9191 Survey Exit Date: 3/17/11

POC Reviewed By: [illegible] Date Approved:

Desk Audit:

2567 signed and dated: yes Vickie Griffin Completed Date: 3/31/11

	Tag # C105	Tag # C122	Tag # C123	Tag # C125	Tag # C139	Tag # C143	Tag # C192	Tag # C201	Tag # C243	Tag #	Tag #	Tag #	Tag #
Correction date within timeframe?	3/31/11	3/31	3/31	3/31	3/31	3/31	3/31	3/31	3/31				
Address how to correct situation for specific patients; indicate situation and reason specific patients cannot be corrected.	✓	✓	✓	✓	✓	✓	✓	✓	✓				
If staff change is corrective action taken, specify change made.		✓	✓	✓	✓	✓	✓	✓	✓				
If POC refers to creating new policies/procedures, is a copy should be included?		NA	——	——	——	NO	NA	——	——				
Does the plan address all of the deficient practice?	✓	✓	✓	✓	NO	NO	✓	✓	✓				
If in-servicing is provided, is all pertinent staff to attend identified?	N	N	Y	NA	——	——	——	——	→				
Waiver/Variance requested?													

COMMENTS:

4/20/11 C122 - who will monitor?
C123 - how is education provided to current staff and new staff? who will monitor?
C135 - who will monitor evals are done?
C139 - who " " gurney covers?
need evidence anesthesia machine serviced or removed.
who will monitor suction machine & other equipment is clean, how will they monitor
C143 POC does not address legibility of records (policy attached only)
C ~~192~~ - are hospital records kept accessible to staff if stored in director's office?

03/19/2010 C 192 - was mtg completed c med director, what OK
who will monitor credentialing
C 243 - how is Temp & humidity monitored →
Called 4-20 - [illegible]

what date

@ 244 - was preventive maintenance for emergency power. Who will monitor?

- 4/21/11 @ 1 30 pm - Left a voicemail @ the adm staff to let them know we needed add'l information and to call back and ask for Wanda, Yolanda or Deb.

- 4/21/11 @ 1 45 pm - Vicki Griffin returned call - add'l info needed was given to Vicki - Vicki states will get this sent to me & will put this to the attn of Wanda in a fax

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

March 25, 2011

Vickie L. Griffin, Administrator
Akron Women's Medical Group
692 East Market Street
Akron, OH 44305

RE: Akron Women's Medical Group - License: 0969AS
Survey Completed on March 17, 2011

Dear Ms. Vickie L. Griffin:

The Ohio Department of Health, under the authority of Chapter 3702 of the Ohio Revised Code, inspects Health Care Facilities to determine compliance with the licensure requirements set forth in Chapter 3701-83 of the Ohio Administrative Code. To attain and maintain licensure, a health care facility must be in compliance with each licensure requirement and not have any violations that jeopardize the patients' health and safety or seriously limit the facility's capacity to provide adequate care and services.

On the date noted above, we completed a inspection of your facility and cited the violation(s) annotated on the enclosed form. Therefore, in order to recommend your agency for licensure, we must receive an acceptable plan of correction **signed and dated within ten (10) calendar days** after you receive this notice. **Failure to provide an acceptable plan of correction may result in denial, revocation, or non-renewal of your license.**

This plan of correction must contain the following at a minimum:

What action(s) will be accomplished to correct the situation(s) or condition(s) causing or contributing to the noncompliance.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance/improvement program will be put into place.

The Plan of Correction must be written on the enclosed Statement of Deficiency form.

The projected date of correction must not exceed 30 days from the date of inspection exit date unless approval for an extended period for correction is obtained from this office.

Where documentary evidence of corrective action is appropriate, such evidence should accompany the plan of correction wherever possible. When this is not possible, these documents should be provided not later than the latest correction date submitted in your plan of correction **and accepted by this office**. Evidence of compliance may include documentation of facility monitoring, in-service training records, consultant reports, work orders, purchase orders, invoices, photographs, or other information that would confirm compliance.

Normally, an onsite revisit will be conducted to verify corrective action has been taken per the plan of correction. However, after our review of the plan of correction and any evidence of compliance, it is possible that an onsite visit will not be required. If this is the case, you will be advised by phone that your plan of correction was accepted and that the appropriate licensure action will be recommended to the licensure administrator.

If you have any questions regarding this notice, please feel free to contact me at (614) 387-0801.

Sincerely,

Wanda L. Iacovetta, RN/PHN

Wanda L. Iacovetta, R.N.
Non Long Term Care Unit Supervisor
Bureau of Community Health Care Facilities and Services
Division of Quality Assurance

WLI/cc

Enclosure: STATE FORM Licensure

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

Ted Strickland/Governor

Alvin D. Jackson, M.D./Director of Health

April 15, 2010

Carol A. Westfall, Administrator
AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OH 44305

Re: AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OH 44305

Facility Type: AMBULATORY SURGICAL FACILITY
Facility ID: 0969AS
Capacity: 1 Operating Rooms

Dear Ms. Westfall:

The enclosed AMBULATORY SURGICAL FACILITY license, effective April 01, 2010, approves your request to operate the above facility.

For online information regarding the licensure process, e.g. forms, rules (Ohio Administrative Code (OAC)) and regulations (Ohio Revised Code (ORC)), visit the Ohio Department of Health web site at http://www.odh.ohio.gov.

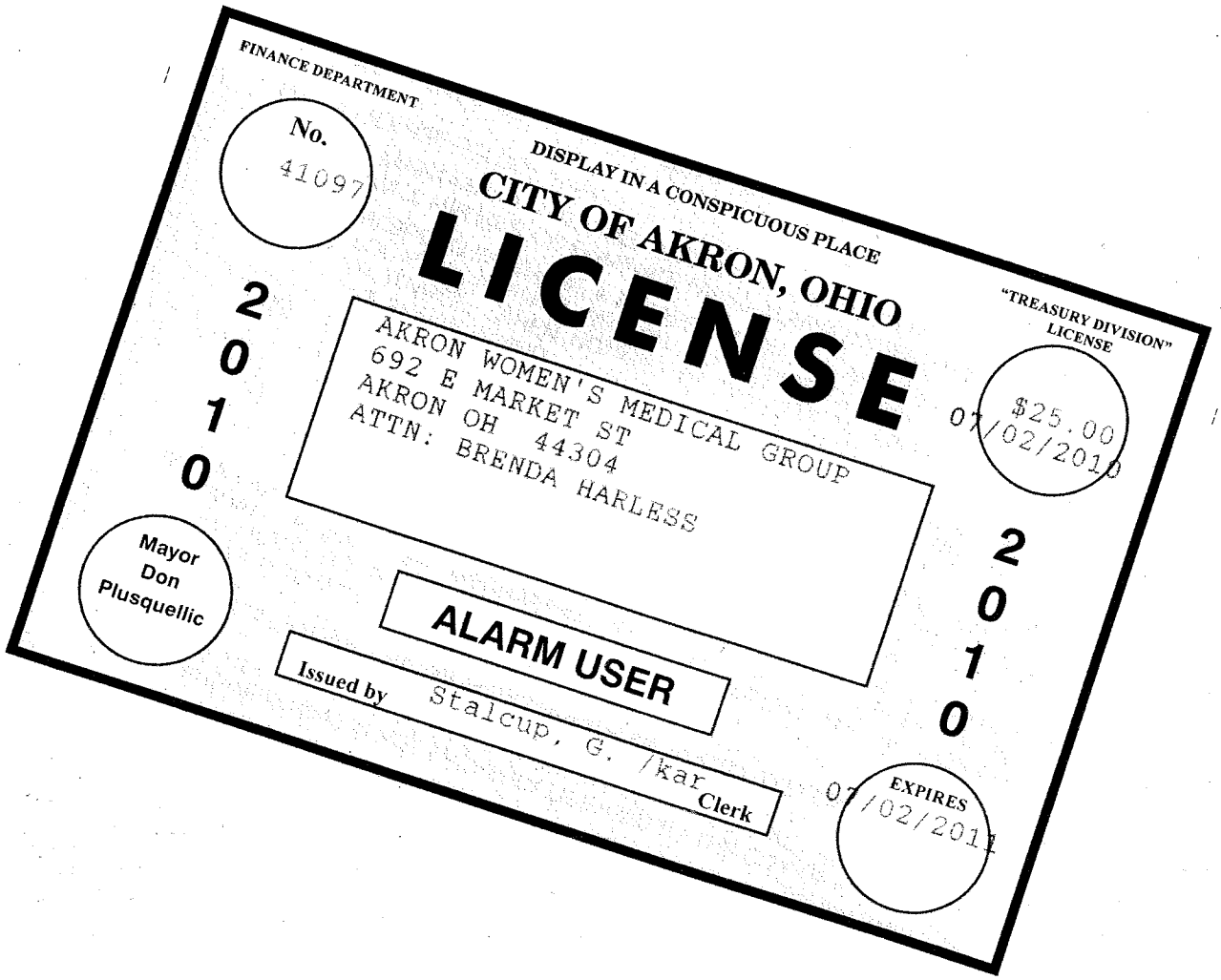
Questions regarding the licensure process may be directed to our e-mail address, liccert@odh.ohio.gov or by calling Charlene Valentine, Licensure Specialist, at (614) 466-7713.

Sincerely,

Bridgette C. Smith, Licensure Administrator
Bureau of Information and Operational Support
Division of Quality Assurance

enclosure

cc: BCHCFS
State Fire Marshal's Office
Certification
Licensure File



FINANCE DEPARTMENT

No. 41097

DISPLAY IN A CONSPICUOUS PLACE

CITY OF AKRON, OHIO

LICENSE

"TREASURY DIVISION" LICENSE

$25.00
07/02/2010

AKRON WOMEN'S MEDICAL GROUP
692 E MARKET ST
AKRON OH 44304
ATTN: BRENDA HARLESS

2010

2010

Mayor
Don
Plusquellic

ALARM USER

Issued by Stalcup, G. /kar Clerk

EXPIRES
07/02/2011

STATE OF OHIO
OHIO DEPARTMENT OF HEALTH

AMBULATORY SURGICAL FACILITY LICENSE

Hereby issued in accordance with Chapter 3702. of the Ohio Revised Code and Chapter 3701-83 of the Ohio Administrative Code to :

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OH

Facility ID #: **0969AS**

Capacity: **1 OPERATING ROOMS**

Originally Licensed: **April 01, 2010**

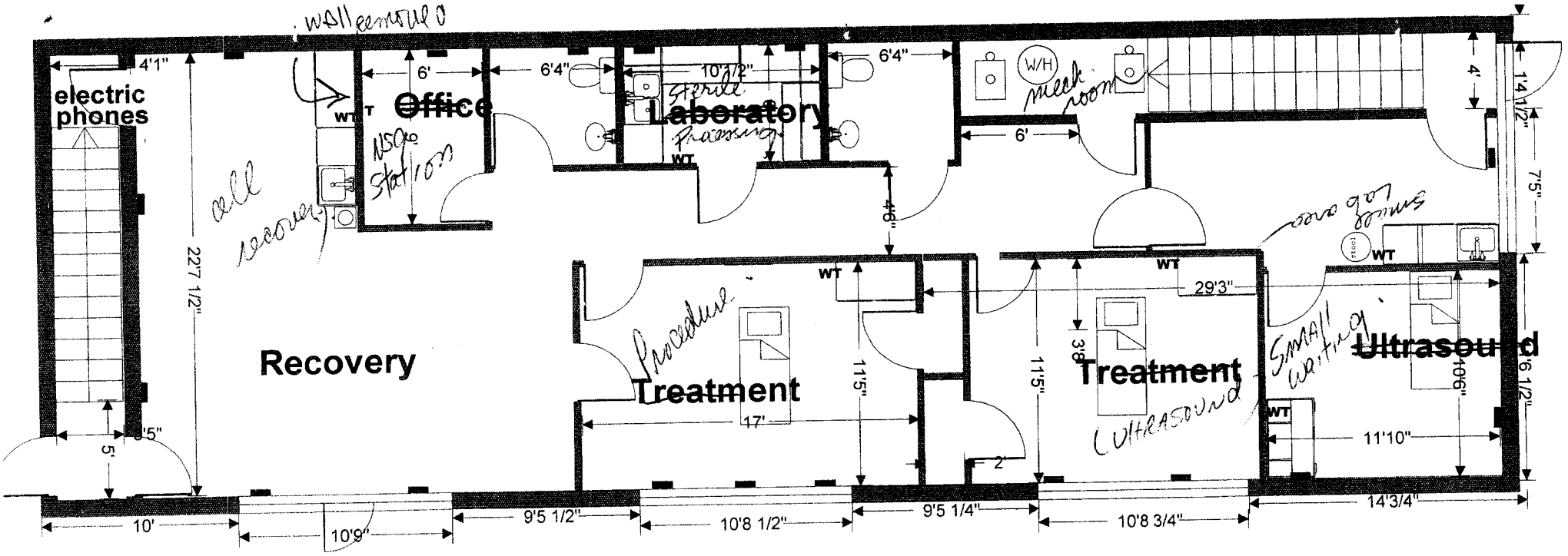
Renewal Month: **April**

In witness thereof Alvin D. Jackson, M.D.

Alvin D. Jackson, M.D.
Director of Health

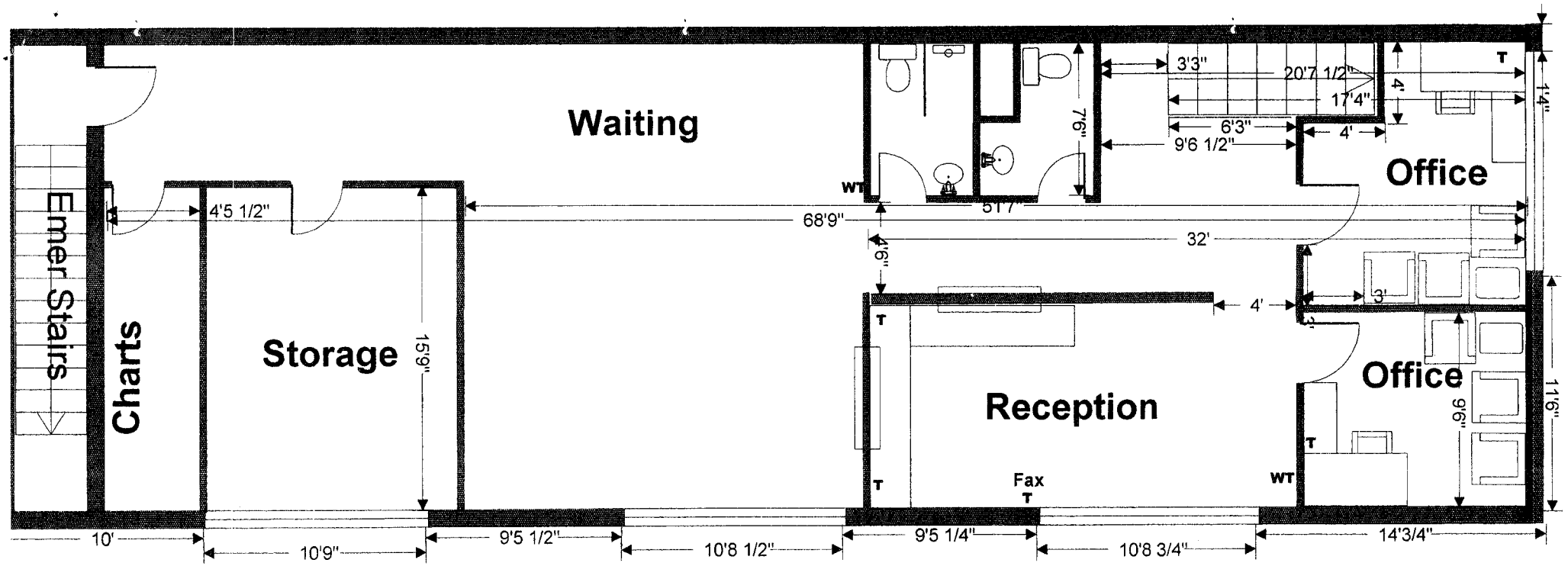
DEPARTMENT OF HEALTH
STATE OF OHIO

This is a non-transferable license and must be posted in a conspicuous place in the facility.



692 E. Market St 1st Floor

Akron Women's Medical Group



692 E. Market St 2nd Floor

Akron Womens Medical Group

The three-week period after your abortion is very important. This pamphlet contains the information and instructions you need to assure an easy and worry-free recovery. Please read this pamphlet carefully and keep it until you have had your check up in 2-5 weeks.

BLEEDING

Some women bleed very little or not at all after the abortion procedure. Other women have a heavier flow, more like a heavy period which is sometimes accompanied by clotting. Both conditions are normal, and there is no way to know before hand which one you will experience.

In general you can expect to have some spotting for 2-4 weeks after the abortion procedure. How much and how long varies with each woman. You should call us immediately at 1-800-428-3673 or (330) 535-9191 if you:

- Are soaking through a pad within one hour and feeling weak or dizzy.
- Are Passing clots larger than a golf ball

TEMPERATURE

You should take your temperature 1-2 times a day for the next two days.

- **CALL US IF YOUR TEMP IS OVER 100.0F**

NOTE: If you decide to call us with any medical problem, we will want to know your temperature within an hour before you call. Please take your temp do not assume that you have a fever.

RESUMING NORMAL ACTIVITIES:

You can resume normal activities, work, school, and housekeeping immediately. You should avoid strenuous activities for the next three weeks. Please note if you do strenuous activities you will bleed heavier.

CRAMPING

Some women may experience cramping for several days after the procedure. You can take any non-aspirin pain reliever as directed to relieve the discomfort. DO NOT take pain relievers with aspirin in them because they thin the blood and will tend to make you bleed heavier.

- Call us at (330) 535-9191 if you have abdominal pain which is not relieved by the medication described above.
- DO NOT TAKE ANYTHING CONTAINING ASPIRIN.

BREAST SORENESS

A small percentage of women experience some increased breast tenderness for the first few days after the procedure. Some women even produce milk. If this happens to you, simply wear a tight fitting bra or place ice bags on your breasts. Milk productions will usually diminished in a few days.

MOOD CHANGES

After an abortion some people feel a slight "down" or "blue" period. This is not something to worry about. The cause is a shift in your hormones from the pregnant to the non-pregnant state. If you experience a mild depression, do not worry about it. It should disappear in a few days. If the depression seems to linger please feel free to call and speak with one of our counselors.

INTERCOURSE, BATHS, AND TAMPONS

As you know, the cervix (opening of the uterus) has been dilated during the abortion procedure. For this reason it is important to make sure that nothing enters the vaginal area. By not putting anything into the vagina, you will protect yourself from infection.

- DO NOT have intercourse for 3 weeks, Do not douche
- NO TAMPONS, SWIMMING, HOT TUBS, BATH TUBS

DR RAYMOND ROBINSON OR DR M.H. REZAEE was your doctor today. Ask For them if you need to call the after hours at 330-535-9191.

FOLLOW-UP EXAM

The three-week follow-up exam is in important way for you to know that your body has returned to normal after the abortion procedure. It is also a good time to decide upon your choice of birth control if you do not choose a method the day of your procedure. If you started the pill during this three-week period, you may want to discuss any side effects you are having with the doctor during your follow-up exam. You may return to The Akron Women's Medical Group for your follow-up. You can also go to a Planned Parenthood or your own doctor. It is very important that you are checked approximately three weeks after your procedure.

Ongoing Care

You will start your period in four to six weeks. After your period has returned to a normal cycle, there is no way that anyone, even a doctor, can tell that you have had an abortion. So you need not worry about that.

What you should be concerned with is that your reproductive system stays healthy and receive proper and regular medical attention. That means:

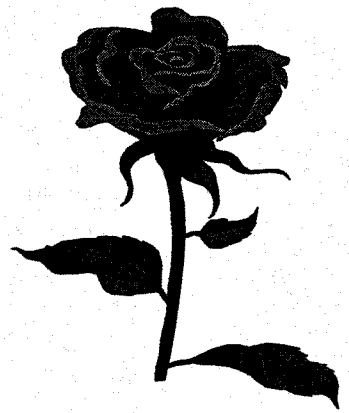
- ♣You should have a Pap test at least once a year.
- ♣Have your IUD or diaphragm checked at least once a year.
- ♣Have your pill prescription renewed at least once a year.
- ♣Consult your physician or clinic if you want to change birth control methods or if you are having any problems with your method.

If you do not have a regular gynecologist or clinic, you may want to use the Akron Women's Medical Group. We offer full, ongoing gynecological care. Please ask your counselor or inquire when you come for your follow-up.

PROBLEMS, QUESTIONS AND CONCERNS

We hope that you had a pleasant experience at our clinic today. However, sometimes you may feel that your needs have not been met in some way. If you have any problems, questions or concerns about your treatment at our facility today please call the Associate Director at 330-535-9191.

What to expect after the procedure



FREE PREGNANCY TESTING
ABORTIONS THROUGH 22 WEEKS
EDUCATIONAL SERVICES

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, Ohio 44304
(330) 535-9191
TOLL FREE 1-800-428-3673
WWW.AWMG.INFO

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OH 44305
1-800-428-3673
330-535-9191

WELCOME TO AKRON WOMEN'S MEDICAL GROUP! Please read this form carefully before you begin your paperwork. If you have any questions regarding this form **PLEASE ASK NOW.**

Please be advised, and remember to advise your ride that you need to be prepared to be here **TWO TO EIGHT HOURS** on your appointment days. Also, note that while we realize that you may have signed in before another patient, there are instances when it will be necessary to change the order in which you are called.

In Ohio, there is a mandatory 24-hour wait between when you meet the doctor and when your abortion can be done. For surgical procedures, this may mean that if you have not talked to the doctor by noon, you will not have your surgery scheduled the next day. If this is going to be a problem come to the front window and we will reschedule your appointment to a time when you can be here longer.

We try to balance patient needs with legal requirements and the logistics of scheduling. **Thank you in advance for your cooperation and understanding.** This makes a long day for our patients, their escorts and our staff. However, please be aware that even though it may appear as though things may be moving slowly and in some instances come to a complete stop, there is activity going on in different parts of the clinic. You and/or your loved one will receive the same individualized attention when it is their turn.

Please bring the following items when you are called to the window to be checked in:

1. Your payment in the form of a money order, MasterCard, Visa or Discover card. **No personal checks will be accepted as payment for services.**
2. Your picture ID.
3. Your insurance or medical card if you are using either one. The insurance must be verified before you can be seen. This may take a day or two so if you plan on using insurance and have not been pre-approved you must be rescheduled.
4. (If you plan anesthesia) Your escort must sign the drivers consent sheet. It is the last sheet on your clipboard.

After you have signed in, please be seated and begin completing the paperwork on your clipboard remembering to:

1. Complete each form **except** the witness sections; please leave these areas blank.
2. Double-check the fronts and backs of each form.
3. Please use the restroom before your ultrasound.
4. Once you have completed your paperwork, you will **hold onto your clipboard until you are called to the counseling office.**

PATIENT SIGNATURE _____ **WITNESS** _____

AKRON WOMEN'S MEDICAL GROUP
692 E. Market St.
Akron, OH 44304
330-535-9191

To all patients of Akron Women's Medical Group:

Effective immediately, there will be no refund of your first day fee $265 under any circumstances. That fee is held by Akron Women's Medical Group for payment of time of the physician, staff, and building use. It pays for ultrasound, lab, counseling, and paperwork. Please DO NOT ask for a refund of your first day fee.

Also there is no refund of anesthesia fees, if you elect general anesthesia and at the time of your procedure, you have eaten or drunk anything and you cannot have anesthesia because of your error. You will not be refunded any anesthesia fees.

_____ Patient Siganature

_____ Witness

_____ Date

STATE OF OHIO
MANDATED CONSENT AND CERTIFICATION

1. At least 24 hours before the performance of my abortion procedure, I have received information from a physician, verbally or by other non-written means of communication, regarding the nature, purpose and medical risks of the particular abortion procedure to be used.

_____ INITIALS

2. At lease 24 hours prior to my abortion, I have been informed of the probable gestational age of my pregnancy.

_____ INITIALS

3. At least 24 hours prior to my abortion, I have been informed of the medical risks associated with carrying this pregnancy to term.

_____ INITIALS

4. Before the performance of my abortion procedure, I have received the information described in paragraph 1-3 from a physician in an individual, private setting, and have had adequate opportunity to ask the physician my questions about the abortion that will be performed. I have had my concerns addressed pertaining to my election to have a voluntary abortion performed at the Akron Woman's Medical Group, Inc. All my questions have been answered to my satisfaction.

_____ INITIALS

5. At least 24 hours prior to the performance of my abortion procedure, I have been informed
6. of the name of the physician who is scheduled to perform my abortion procedure.

_____ INITIALS

7. At least 24 hours prior to my abortion, I have received copies of the State of Ohio mandated information. I have been informed that the State of Ohio prepares these materials and that they describe the embryo or fetus, and list the agencies that offer alternatives to abortion. I understand that I may choose whether or not to examine these materials, and that the physician and staff of the Akron Woman's Medical Group, Inc. may disassociate themselves from the materials and do not attest to the accuracy of the information.

_____ INITIALS

Please initial one:

I choose to read the state pamphlets _____

I choose not to read the state pamphlets_____

Patient's Signature _____ Date/Time_____

Witness Signature _____ Date/Time_____

Physician's Signature _____ Date/Time the information Described in paragraphs 1-6 is provided.

_____
PUT INTO TAPE WHEN CALLED FOR APPOINTMENT

8. I consent to this abortion voluntarily, in an informed and intelligent manner, without coercion by any person. Further, I am not under duress or the influence of alcohol, drugs, or prescription medications that may affect my judgment.

_____ INITIALS

9. I have PERSONALLY SPOKEN WITH MY PHYSICIAN AND A WITNESS FACE TO FACE IN A PRIVATE SETTING AND HAVE SIGNED THIS FORM AT LEAST 24 HOURS PRIOR TO THE PERFORMANCE OF MY ELECTIVE ABORTION AS REQUIRED BY OHIO HOUSE BILL 421.

_____ INITIALS

Patient's Signature _____Date/Time_____

Akron Women's Medical Group
692 East Market Street
Akron, OH 44305
330-535-9191

THE AKRON WOMEN'S MEDICAL GROUP, INC.
AFFIDAVIT OF REFUSAL OF STATE MANDATED MATERIALS

I, _____, do state and attest that The Akron Women's Medical Group, Inc., did offer to me the State Mandated Materials on Abortion and Pre-Natal Development, including two pieces—a listing of all other pregnancy related services in the area and a photographic journal of the gestation of pregnancy—a MINIMUM of 24 hours prior to my abortion procedure in that facility.

_____
Initials

I do also state and attest that I, of my own inclination and with no coercion or pressure from any member of The Akron Women's Medical Group, Inc., have opted to exercise my right NOT to view the State Mandated Materials by informing that facility of my choice and refusing the State Materials offered. I have made this choice, and it is fully my responsibility.

_____
Initials

_____
Patient Signature

_____
Witness

_____
Date

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44304
1-800-428-3673
330-535-9191

Are you willing to discuss feelings about abortions in your consultation today with the doctor?

_____YES _____NO

_____I have no concerns.

_____I don't understand how an abortion is done.

_____I would like to learn more about how an abortion is done.

_____I an scared that having an abortion is dangerous.

_____I am afraid it will hurt.

_____I am wondering what the pregnancy looks like.

_____I am worried that I won't be able to have children when I am ready

_____I am worried about how to avoid getting pregnant in the future.

How are you feeling today? (Circle all that apply)

Confident	angry	happy	trapped	relieved	mad
Curious	Strong	relaxed	sad	guilty	numb
Peaceful	ashamed	afraid	resolved	alone	depressed

Have you talked to anyone about your decision? YES NO

_____ _____ _____

Patient Signature Patient Educator Date

Akron Women's Medical Group
692 East Market Street
Akron, OH 44304
1-800-428-3673
MEDICAL HISTORY

Patient's name:_____

What was the first day of your last menstrual period (first day of bleeding)? _____
What is the total number of PREGNANCIES before this one? _____
Number of live births? _____ Which pregnancies? _____
Number of children now living? _____
Number of miscarriages you have had? _____Which pregnancies? _____
Number of pregnancy termination's you have had? _____Which pregnancies? _____

If you have ever had any of the following, check the appropriate box and explain in the space provided at the end.

	YES	NO
A. Obstetric of GYN problems (toxemia, pelvic infection, Cesarean, Ectopic pregnancy, removal of tube or ovary)	____	____
B. Infectious Disease	____	____
C. Reactions to medications or drugs	____	____
D. Previous Surgeries	____	____
E. Allergies	____	____
F. Sickle Cell Anemia	____	____
G. Other Anemia's	____	____
H. Venereal diseases	____	____
1. Have you ever had Chlamydia?	____	____
2. Have you ever had herpes simplex?	____	____
3. Have you ever had Syphilis?	____	____
4. Have you ever had Scabies?	____	____
5. Have you ever had Genital Crabs?	____	____
6. Have you ever had Genital Warts?	____	____
7. Has your partner ever had a S.T.D.?	____	____
8. Have you ever had Pelvic Inflammatory Disease (PID)	____	____
9. Do you now have any Vaginal Sores?	____	____
I. Diabetes	____	____
J. Accidents	____	____
K. Tendency to bruise easily	____	____
L. Bleeding tendencies (hemorrhaging, excessive bleeding)	____	____
M. Heart problems (murmurs, etc.)	____	____
N. Neurological problems	____	____
O. Liver problems (hepatitis, jaundice)	____	____
P. Lung problems (asthma, abnormal x-rays)	____	____
Q. Intestinal problems	____	____
R. Kidney problems	____	____

MEDICAL HISTORY PAGE 2

	YES	NO
T. Orthopedic (bone) problems	____	____
U. Previous hospitalizations	____	____
V. Blood clots in leg	____	____
W. High Blood Pressure	____	____
X. Have you seen a psychiatrist in the past 5 years?	____	____

Y. Do you smoke cigarettes? If yes how many packs per day?_____

Z. Do you take Pain Pills? If yes what kind and how often?_____

AA. Do you take any drugs? Including street drugs? What kinds?_____

BB. Do you use Alcohol? If you, when was your last drink? _____

CC. Do you take any kind of prescribed medications? Please list

_____

If you have responded "YES" to any of the questions please use the following space to explain

_____

_____

I HEREBY DECLARE THAT I HAVE READ THE FOREGOING AND KNOW THE CONTENTS THEREOF AND THE SAME IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THE AKRON WOMEN'S MEDICAL GROUP AND ITS STAFF WILL RELY UPON THE REPRESENTATION HEREIN, AND IN THE EVENT THAT ANY OF THESE REPRESENTATIONS ARE UNTRUE IN WHOLE OR IN PART, THE AKRON WOMEN'S MEDICAL GROUP IS HEREBY ABSOLVED FROM ANY LIABILITY CAUSED BY ITS RELIANCE ON SUCH UNTRUE STATEMENTS.

PATIENT SIGNATURE_____

PATIENT EDUCATOR SIGNATURE_____

DATE:_____

Akron Women's Medical Group
692 East Market Street
Akron, OH 44305
1-800-428-3673
330-535-9191

The State of Ohio requires that we get certain statistical information on our patients. Your name or address will not be mentioned in this information and everything is strictly confidential.

1. What is your zip code:_____.

2. What **COUNTY** IN OHIO do you live in:_____.

3. Are you a resident of the State of Ohio?_____If not what state?_____

4. What is your age?_____

5. What is the highest number of years completed in school?_____

6. What is your marital status?_____

7. What is your race or ethnic group?_____Are you Hispanic?_____

8. Number of living children you have?_____The date of your last live birth?_____

9. How many miscarriages have you had?_____

10. How many abortions have you had?_____Date of last?_____

11. How many times have you been pregnant?_____

12. Why are you terminating your pregnancy_____.

13. Were you on birth control when you got pregnant? What Kind? _____.

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44305
1-800-858-8980
330-535-9191

TO OUR VALUED PATIENTS

Welcome to Akron Women's Medical Group. We are pleased you have selected us to care for your medical needs. It is absolutely critical for you to give your full and accurate medical history. Correct and current medical information is of utmost importance so that our doctors may provide you with the most appropriate medical treatment. If you did not give correct information at the time you scheduled this appointment or on the forms you have completed, please correct the information NOW.

It is also extremely important for you to follow the instructions given to you when you made your appointment. You must have a responsible person to drive you home after you are discharged. If you are receiving sedation or general anesthesia and do not have someone to drive you home on the day of your surgery notify the front desk NOW. Also, if you are receiving sedation or general anesthesia you will not be able to have anything to eat, drink, smoke, or chew after 12 a.m. midnight before you have your procedure.

You were previously instructed to remove all makeup, jewelry, nail polish or one artificial nail on the day of your procedure. A failure to follow those instructions could result in rescheduling your appointment or going without anesthesia. If the clinic agrees to proceed with your surgery even though you may not have removed all jewelry, makeup and nail coverings, the Akron Women's Medical Group, its staff and physicians are hereby released from all responsibility as stated below:

1. Akron Women's Medical Group, Its staff and physicians cannot be held responsible for any lost or damaged jewelry.
2. Akron Women's Medical Group, its staff and physicians cannot be held responsible for any damage that may occur to a patient that would involve the wearing of jewelry during and immediately after the surgical procedure or the attempted removal of artificial nail coverings prior to surgery.

Please be advised: If for any reason you are unable to have your termination procedure, you will be charged for any and all services rendered today. These charges will be deducted from the total fee you have already paid and you will be refunded the balance via U.S. Mail. The following is a list of individual fees for the most common services received by patients.

Laboratory Pre-Testing	**$50.00**
Physician Consultation/Advisory Session	**$120.00**
Ultrasound/Sonogram	**$150.00**
National Abortion Federation	**$5.00**

If you happen to have the Rh Negative blood type, you will receive a Rhogam Injection after your surgery or before you take the RU-486 pill. An additional charge of **$60.00** for first trimester patients and **$110.00** for second trimester patients will be assessed and payment is due before your termination procedure.

I have read the above information and hereby certify that I have made a full and correct disclosure of my medical history, and have followed all instructions given to me.

Patient Signature_____Date_____

Parent/Guardian Signature

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OH 44305
1-800-428-367
330-535-9191

Dear Patients:

The state of Ohio requires us to ask you about advanced directives. If you have a living will or what you would like to be done in the event of a terminal injury. Do you have someone with durable health care Power of Attorney to make decisions for you in the event you are not conscious or capable of making decisions yourself.

If you do not at this time, have these decisions in place, we can give you information.

Patient:_____

Date:_____

MAKING CRUCIAL DECISIONS

Akron Women's Medical Group recognizes a patient's right to make health care decisions. As an adult, you are capable of asking questions, understanding information and judging the risks, benefits, and alternatives of treatment. You have the right to make decisions about your medical treatment. However, due to illness or injury you may lose the ability to participate in discussions about your medical treatment. Someone else might then have to make those decisions for you. Legal documents called "Advance Directives" can be used to prepare for such a situation.

If you do not at this time, have these decisions in place, we can give you information on how to make a living will the website is:
http://www.proseniors.org/Law_Library/Health/Living%20Will.pdf

_____I do not have an advance directive, and do not want information about one at this time.
_____I do have an advance directive and will supply a copy of it you your office.
_____I do have an advance directive, and have a copy for your facility with me today.
_____I would like more information about advance directives.

_____ _____
PRINT PATIENT NAME PATIENT SIGNATURE

_____ _____
PATIENT EDUCATOR SIGNATURE DATE

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OH 44304
1-800-428-3673
330-535-9191

CONSENT FOR ULTRASOUND

The ultrasound is a test, which is done to determine the length of pregnancy using sound waves, which bounce off the abdomen. A picture of the pregnancy can be taken and then measured. This will show how far along the patient is into the pregnancy. The measurement is in centimeters or millimeters, which is then translated into the number of weeks. Another name for ultrasound is a sonogram.

An ultrasound is painless and does **NOT** harm the patient or the pregnancy.

A description of the ultrasound:

- The patient lies on a bed with her abdomen exposed.
- A cold feeling jelly substance is applied.
- An instrument resembling a microphone is moved over the abdomen using sound waves.
- Measurements can be taken to determine the number of weeks into the pregnancy.
- The average length of the test is 5-10 minutes, but this does vary with each patient.
- A vaginal ultrasound may need to be done in early pregnancies.
- Remember that the test is painless and is not harmful to the patient or the pregnancy.

Results are given very soon after completion of the test.

The Ultrasound is a necessary part of the evaluation for the abortion procedure. I request and consent to an ultrasound test. I fully understand that there is a charge of $150.00 for the ultrasound. This fee has already been paid as part of your procedure. However, if your procedure is not done the fee of $150.00 will be deducted from any refund owed to you.

STATE OF OHIO ULATRSOUND LAW

UNDER OHIO REVISED CODE, SECTION 2327.561, I UNDERSTAND THAT WHEN THE ULTRASOUND IS DONE I HAVE THE FOLLOWING RIGHTS.

- **I have the opportunity to view the ultrasound image of my pregnancy.**
- **I have the right to get a physical picture of the ultrasound image**
- **I understand that there shall be no additional charge if I want a picture**

_____ _____
Patient's signature date

_____ _____
Patient Educator's Signature date

CONSENT TO ABORTION PLEASE READ AND FILL IN ALL APPROPRIATE INFORMATION

I, _____, age _____, hereby give my consent to and request and authorize M.H. Rezaee or Dr. Raymond Robinson an independent practitioner, to perform upon me an abortion and if any unforeseen conditions arise in the course of the abortion that in his/her judgment call for procedures different from or in addition to those now contemplated, including but not limited to the administration of anesthesia and the administration of Rhogam to perform such procedures. I further consent to and request and authorize said doctor and his/her assistants to do whatever else he/she deem advisable in the exercise of his or their best medical judgment.

_____
Initial

PAST MEDICAL HISTORY
I have fully told my past and present medical history, including allergies, blood conditions, prior medications or drugs taken, and reactions I have had to anesthetics, medicines and drugs.

_____
Initial

LAST MENSTRUAL PERIOD/DURATION OF PREGNANCY
I understand that the decision to terminate this pregnancy will be based part on the information given about my last normal period, and in part on the pelvic exam and/or ultrasound screening. The first day of my last menstrual period was: _____/_____/_____

_____
Initial

PURPOSE AND ALTERNATIVES
I fully understand the purpose of this pregnancy termination procedure is to end this pregnancy. I understand that the alternatives to abortion are to continue this pregnancy to term and either care for the child myself or give it up for adoption. I have considered these alternatives and the staff at the Akron Women's Medical Group has offered to make referrals to appropriate agencies for birth and/or adoption. I reject these alternatives and request that the abortion procedure be performed.

_____
Initial

COMPLICATIONS OF THE PREGNANCY TERMINATION (ABORTION) PROCEDURE
I have been told of the minor and major complications that MAY follow an abortion procedure, as MAY occur after any surgical procedure. The following are examples of the kinds of physical complications that can occur after an abortion. These complications could cause prolonged illness, need for blood transfusion and permanent inconvenience and disability.

a. Infection of the uterus; may require antibiotic therapy, and rarely, can lead to loss of child bearing capacity.

_____
Initial

b. Failure to remove all of the tissue (incomplete abortion); may require re-evacuation of the uterus.

_____
Initial

c. Hemorrhage (heavy bleeding); May require re-evacuation of the uterus to determine the cause of excessive bleeding.

_____
Initial

d. Perforation or injury to the uterine walls. This could cause pelvic bleeding and/or infection and possible bleeding and infection in the abdomen. This may result in a hysterectomy.

_____
initial

f. A remote chance that one or more nerves will be injured during the course of the termination is possible.

_____
Initial

g. Laceration (tearing of) the cervix; may require suturing (stitches).

_____
Initial

h. Continuing pregnancy; this may be due to: failure to interrupt the pregnancy, requiring a re-evacuation of the uterus if desired; multiple pregnancies; double uteri; or pregnancy in the fallopian tubes (ectopic pregnancy), the latter requiring hospitalization and surgery.

_____
Initial

i. As previously stated, some of the complications of this procedure can require further major surgery; some could potentially result in sterility; and very rarely, some of the complications can be fatal. There are other potential complications from the abortion procedure in addition to the ones mentioned her. However, it is not possible to advise you of every imaginable complication. The complications referred to are very unlikely. The purpose of this consent form is merely to insure that your decision to have an abortion is not made in ignorance of this kind of operation.

_____
Initial

POST TERMINATION EMOTIONAL DISTRESS

The Surgeon General has studied in depth the possibility of long term clinical depression after a termination procedure. The findings suggest there is no long term lasting emotional distress post abortion. However, in some cases, counseling may be warranted to express issues of grief and loss surrounding the termination procedure. Referral lists are available to those women requesting this service.

_____
Initial

PROVISION OF MEDICATION, LOCAL & GENERAL ANESTHETICS AND PAIN KILLERS

I understand that there may be some risks involved in the prescription of medicines. I consent to the physician giving me local anesthetics around the cervix excluding any which I reported as causing a known allergic reaction. I understand that local anesthetics do not always eliminate all pain, and that in a small number of cases, local anesthetics cause extremely severe reactions, including rare instances of convulsions, cardiac arrest or prolonged unconsciousness.

_____
Initial

I understand the risks of MONITORED ANESTHESIA CARE range from minor (nausea, phlebitis) to severe (cardiac arrest, respiratory failure, prolonged unconsciousness), and even death. I warrant that I have NOT had anything to eat, no mints or gum, or anything to drink since midnight last night with the exception of: _____.

_____
Initial

HIV, AIDS, AND HEPATITIS SCREENING:

I, _____, give my permission to Akron Woman's Medical Group to send my blood specimen's to the laboratory for HIV, A.I.D.S and Hepatitis screening, ONLY in the event an employee at Akron Woman's Medical Group has been exposed to my blood.

ALL TEST RESULTS ARE STRICTLY CONFIDENTIAL. _____
Patient's Signature

LABORATORY

I consent to diagnostic studies, tests, sonograms, and any other treatment or courses of treatment relating to the diagnosis of my condition for procedures set forth herein. I understand that the purpose of a sonogram is to determine gestational size only and NOT to rule out or to determine fetal abnormalities, deformities, or the sex of the fetus. I also consent to the disposal of any tissue or other parts of the contents of my uterus (womb) which may be removed during the termination procedure in the discretion of the physician or the Akron Women's Medical Group. I acknowledge that I may voluntarily receive tests for some sexually transmitted diseases. I am also aware that I may be contacted for referral and further examination and treatment as a result of this testing. I also consent to the administration of Rhogam (or equivalent) should my blood be Rh negative. I agree to pay for such medication. My confidentiality will be respected whenever possible.

_____
Initial

FOLLOW-UP VISITS AND EMERGENCIES

I UNDERSTAND THAT MANY POST-ABORTION PROBLEMS CAN BE EASILY CORRECTED IF THEY ARE TREATED PROMPTLY. I UNDERSTAND THAT IF I HAVE EXCESSIVE BLEEDING, SIGNS OF INFECTION OR PAIN, IT IS IMPORTANT TO CALL THE NUMBER GIVEN TO ME BY MY ADVISOR/COUNSELOR, AND COME IN FOR A MEDICAL EXAM AS SOON AS POSSIBLE. I AM AWARE THAT A TWENTY-FOUR HOUR ANSWERING SERVICE IS AVAILABLE.

_____
Initial

I understand that it is my responsibility to take my medications as directed by the nursing staff, to bring to the attention of the Akron Women's Medical Group any unusual symptoms following the abortion, as outlined in the pamphlet What To Expect After Your Procedure, and to have a post-operative check up in 2-3 weeks, including a pregnancy test as recommended.

_____
Initial

I UNDERSTAND THE AKRON WOMEN'S MEDICAL GROUP, INC. AND THE TREATING PHYSICIAN(S) WILL NOT BE RESPONSIBLE FOR ANY COMPLICATIONS OR CONSEQUENCES IF I FAIL TO INFORM THEM OF ANY PROBLEM IN A TIMELY MANNER OR IF I FAIL TO HAVE FOLLOW-UP CARE.

_____
Initial

I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO ME BY ANY PHYSICIAN, OR OTHER STAFF MEMBER OF THE AKRON WOMEN'S MEDICAL GROUP, CONCERNING THE RESULTS OF THE TERMINATION PROCEDURE..

_____
Initial

FOR PATIENTS RECEIVING SEDATION OR MONITORED ANESTHESIA CARE

I understand that:

- Medication administered during the abortion procedure may affect my reaction time.

_____
Initial

- I also agree not to make any judgment calls within the next 24 hours.

_____
Initial

I acknowledge it has been suggested to me that I not operate a motor vehicle within 24 hours and preferable 48 hours of the administration of the medication, and hereby release the attending physician and assistants as well as Akron Women's Medical Group Inc. and any of its affiliates from all responsibility and any ill effects which may result from my not following these instructions.

_____
Initial

ADDITIONAL MATERIALS USED OR FURNISHED TO PATIENT

I have received additional written and/or verbal material specific to my case such as Birth Control information, What to Expect after the Procedure, and How to take your medications.

_____
Initial

I acknowledge that I have read or had this form explained to me; that I fully understand its contents, and that I have been given ample opportunity to ask questions and that my questions have been answered satisfactorily.

_____
Initial

MISSION STATEMENT

Our mission is to be providers of high quality patient-focused healthcare that is accessible, cost effective and meets the needs of our community.

The vision that the Akron Women's Medical Group has is to be the best place to receive care, the best place to practice medicine and the best place for our employees to work.

We at the Akron Women's Medical Group value compassion. We provide care with dignity, concern, kindness and a respect for the community. We foster an atmosphere of teamwork and cooperation.

We strive to exceed the expectations of all our patients by committing value in every aspect of our work. We will enhance quality to all our patients, educating them about their health and empowering them to be partners.

PATIENT CARE

At the Akron Women's Medical Group, Inc. we strive to treat each person with caring, individual attention. We are aware of the fact that you are facing an extremely difficult decision and we want you to have the very best support and medical attention that we can provide. In an effort to make you more comfortable and be sure you know that we assure you the utmost confidentiality, please initial the following statements:

I understand that I have the right to be treated with consideration, respect, and full Recognition of dignity and individuality, including privacy in treatment and personal care needs.

_____
Initial

I understand that I have the right to refuse of withdraw consent for treatment

_____
Initial

I understand I have the right to access my medical records, unless access is specifically Restricted by the attending physician for medical reasons.

_____
Initial

I understand that my medical and financial records shall be kept in strict confidence to the full extent that the law allows.

_____
Initial

I understand that I may receive, upon my request, a detailed explanation of all facility charges, including an itemized bill for services received.

_____
Initial

I verify that I have read, or had explained to me, the previous five statements, and that I understand its contents.

_____
Initial

_____ _____

Patient Signature Date Signature of Parent (if patient is a minor)

Date

AKRON WOMAN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44305
1-800-428-367
330-535-9191

GENERAL ANESTHESIA INSTRUCTIONS

Prior to your procedure under general anesthesia, you are to remove all make-up, nail polish (off at least one nail), and jewelry. You are to have **NOTHING BY MOUTH FROM MIDNIGHT OF THE NIGHT BEFORE YOU ARE TO COME IN FOR YOUR PROCEDURE.**

This includes EVERYTHING. DO NOT DRINK WATER DO NOT PUT ANYTHING IN YOUR MOUTH!!!

If you do have anything by mouth after midnight of the night before your procedure, we will be unable to put you to sleep and you will have to reschedule.

PATIENT_____DATE_____

PATIENT EDUCATOR _____DATE_____

PRE-ANESTHESIA QUESTIONNAIRE

The information you supply below assists in the development of your anesthesia care. Please complete this questionnaire accurately and completely.

Patient Name:_____ **Date:**_____

Age:_____ **Weight:**_____ **Height:**_____

Allergies:_____

Current Medications (Prescription & Non-prescription)_____

Prior Operations_____

YES	NO	
_____	_____	Have you recently had a cold or the flu?
_____	_____	Have you experienced chest pain?
_____	_____	Do you have a heart condition?
_____	_____	Do you have hypertension? (high blood pressure)?
_____	_____	Do you experience shortness of breath?
_____	_____	Do you have asthma, bronchitis or breathing problems?
_____	_____	Have you taken cortisone (steroids) in the last 6 months?
_____	_____	Do you have diabetes?
_____	_____	Have you had hepatitis, liver disease or jaundice?
_____	_____	Do you have a thyroid condition?
_____	_____	Do you have or have you had a kidney disease?
_____	_____	Do you have ulcers or other stomach disorders?
_____	_____	Do you have a haital hernia?
_____	_____	Do you have back or neck pain?
_____	_____	Do you have numbness, weakness, or paralysis?
_____	_____	Do you or anyone in your family have sickle cell trait?
_____	_____	Do you have any muscle or nerve disease?
_____	_____	Have you or anyone in your family had difficulty with anesthesia?
_____	_____	Do you have a bleeding problem?
_____	_____	Do you have loose, chipped, false teeth or bridgework?
_____	_____	Do you wear contact lenses?
_____	_____	Have you ever received a blood transfusion?
_____	_____	Do you smoke? Packs per day?_____
_____	_____	Do you consume alcohol? Drinks per week_____
_____	_____	Have you ever taken street/recreational drugs?
_____	_____	Do you smoke marijuana? When was the last time_____
_____	_____	Have you ever smoked crack? When was the last time_____
_____	_____	Have you ever taken heroin? When was the last time_____
_____	_____	Have you ever taken oxycontin? When was the last time_____
_____	_____	Have you ever taken cocaine? When was the last time_____
_____	_____	Have you ever taken methadone? When was the last time_____
_____	_____	Have you ever taken crystal meth? When was the last time_____
_____	_____	Have you ever taken amphetamines? When was the last time_____
_____	_____	Have you ever taken opiates? When was the last time_____
_____	_____	Have you ever taken any ecstasy? When was the last time_____
_____	_____	Have you ever taken Fentanyl? When was the last time_____
_____	_____	Have you ever taken Vicodin or Prescription pain meds?_____

Please be honest with your drug usage so that we can give you the proper medications.

CONSENT FOR ANESTHESIA SERVICES

I, _____, ACKNOWLEDGE THAT I HAVE ELECTED TO HAVE A PROCEDURE DONE AT THIS FACILITY. All risks regarding the procedure have been explained to me. I desire to have anesthesia services as checked below.

It has been explained to me that ALL forms of anesthesia involve some RISKS and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique, which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including monitored anesthesia care.

1. **AWAKE:**
   No anesthesia. You will feel pain and pressure for 5-10 minutes. If you have a low pain threshold, this option is not recommended. Only your cervix will be numbed.

   _____
   INITIALS

2. **LOCAL SEDATION WITH PAIN RELIEF:**
   A Registered Nurse will start an IV and give you pain medication that will help you relax. You will feel some pain and pressure during the 5-10 minute procedure. You will probably be awake for the procedure.

   _____
   INITIALS

3. **CONSCIOUS SEDATION:**
   A certified registered nurse anesthetist (CRNA) will administer intravenous medication to help you relax. You will still feel some pain and pressure but it will be less intense. You may or may not be drowsy.

   _____
   INITIALS

4. **MONITORED ANESTHESIA CARE:**
   A Certified registered nurse anesthetist (CRNA) will administer intravenous medication to put you to sleep. You will not feel pain or pressure during the procedure. You will wake up in the recovery room. You may not remember the procedure.

   _____
   INITIALS

I hereby consent to the anesthesia service checked above and authorize that it by administered by independent contractors of Akron Women's Medical Group, or other individuals who have credentials to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the staff and the physician. I expressly desire the following considerations to be observed: (or write none):

_____.

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I have had ample time to ask questions and to consider my decision.

_____ _____

Patient's Signature DATE

AKRON WOMAN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44305
1-800-428-3673
330-535-9191

EMERGENCY CONTACT

If during the course of the abortion procedure, any unforeseen conditions or complications arise, and the doctor in his/her professional medical judgement decides that different or additional procedures including but not limited to anesthesia or blood transfusion or the association of another doctor, or hospitalization at a hospital may be necessary, I give my consent to such. I assume all financial responsibility for payment for additional services. I give my permission for my parents, legal guardian, husband, significant other, or family relative as indicted below to be notified by the doctor or staff member. The correct identity, address, phone number and relationship of my emergency contact are set out below.

NAME:_____

RELATIONSHIP:_____

ADDRESS:_____

PHONE NUMBER:_____

AKRON WOMEN'S MEDICAL GROUP
692 EAST MARKET STREET
AKRON, OHIO 44304
1-800-428-3673
330-535-9191

INFORMATION ABOUT PRIVACY PRACTICES FOR HIPPA

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Akron Women's Medical Group
Contact Person: MARISOL, RN, DON
Telephone: 330-535-9191 OR 1-800-428-3673
Fax: 330-535-9925
E-Mail: Carolw1690@gmail.com
Address: 692 East Market Street, Akron, OH 44305

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices I have read and had the opportunity to read this notice.)

PATIENT NAME (please print) _____

PATIENT SIGNATURE _____

Parent or authorized representative (if applicable) _____

Patient Educator _____

AKRON WOMEN'S MEDICAL GROUP
STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of person or organization

_____
Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Akron Women's Medical Group. You should contact the front desk receptionist to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of patient (Print or type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

Akron Women's Medical Group 839 E. Market St. Akron, OH 1-800-428-3673

DISCHARGE INSTRUCTIONS

Please sign discharge instructions after reading and review. You will receive a copy at discharge.

1. Pelvic Rest:

- **Nothing in the vagina for 2-4 weeks. NO douching, NO tampons, NO baths/swimming, NO sexual intercourse.** You can ovulate as soon as 2 weeks after the procedure, which means that you can get pregnant again.
- Vaginal bleeding last 3-5 weeks after the procedure. The amount of bleeding should be similar to being on your period. Passing small clots (grape or quarter size) is normal.
- You will experience strong/painful uterine cramping immediately after the procedure. Uterine cramping/soreness can last up to 1 week after procedure.

2. Activity: ☐Work/School excuse requested and provided.

- Don't drive for 24 hours after the procedure. After receiving sedation, you may feel sleepy, dizzy, nauseous, lightheaded, and/or confused. ***Don't make any major decisions for 24 hours.***
- Return to your normal activities after 48 hours. You may also return to work at that time. Remember that any strenuous or heavy activity can cause your bleeding to become heavy. Don't lift anything heavier than 15 pounds for 48 hours.

3. Diet:

- You may resume your normal diet unless otherwise instructed.

4. Breasts:

- If you were 9 weeks pregnant or more, it is possible to leak clear or whitish fluid (milk) from your breasts. This is a normal affect of hormones. Wear a tight supportive bra 24 hours a day and avoid breast/nipple stimulation until milk dries up. This can take up to 4 weeks.

5. Medication(s):

- Take antibiotics and other medication prescribed by your doctor completely. Start antibiotics after your surgery, preferably after you eat.

☐ Cytotec ☐Doxycycline ☐Flagyl ☐Rhogam ☐Other_____

- Take an over-the-counter pain reliever for pain if needed. Do not take aspirin.
- You may resume at home medications. **Please refer to your doctor if you have any questions about your regular scheduled medications.**

6. Birth Control Method Received: ☐Birth Control Pills ☐Depo Provera IM ☐Other_____

- Start _____ on _____. Remember that the first full pack will not protect you from pregnancy. Use condoms as back-up. Effectiveness of birth control pills decreases when taking antibiotics and/or having stomach sickness (diarrhea/vomiting) that interfares with pill absorption.

7. Follow-Up: It is recommended that you follow-up in 2-3 weeks after your procedure.
Please return on_____

8. Symptoms and When to Call: On-call nurse 24-hour number ***216-233-3005***

- Soaking more than one pad in 1 hour for 4-6 hours.
- Fever over 101.0° for more than 3 days.
- Severe abdominal pain/cramping that doesn't respond to pain medicine.
- Foul smelling vaginal discharge.
- Passing clots larger than a golf ball for more than 2 hours.
- Increased bright red, heavy bleeding.

I have received all of my discharge instructions both verbally and in writing. I understand that Dr. L. Ann Nunnally or Dr. Raymond Robinson or Dr. M.H. Reaace was my physician today. I hold the facility, physician and/or other employees of the facility harmless for the problems arising from my neglect in not following the instructions given above. I have read, understood, and received a copy of the above information.

Patient Signature **Discharge Nurse/Date**

Akron Women's Medical Group 839 E. Market St. Akron, OH 1-800-428-3673

DISCHARGE INSTRUCTIONS

Please sign discharge instructions after reading and review. You will receive a copy at discharge.

1. Pelvic Rest:

- **Nothing in the vagina for 2-4 weeks. NO douching, NO tampons, NO baths/swimming, NO sexual intercourse.** You can ovulate as soon as 2 weeks after the procedure, which means that you can get pregnant again.
- Vaginal bleeding last 3-5 weeks after the procedure. The amount of bleeding should be similar to being on your period. Passing small clots (grape or quarter size) is normal.
- You will experience strong/painful uterine cramping immediately after the procedure. Uterine cramping/soreness can last up to 1 week after procedure.

2. Activity: ☐Work/School excuse requested and provided.

- Don't drive for 24 hours after the procedure. After receiving sedation, you may feel sleepy, dizzy, nauseous, lightheaded, and/or confused. ***Don't make any major decisions for 24 hours.***
- Return to your normal activities after 48 hours. You may also return to work at that time. Remember that any strenuous or heavy activity can cause your bleeding to become heavy. Don't lift anything heavier than 15 pounds for 48 hours.

3. Diet:

- You may resume your normal diet unless otherwise instructed.

4. Breasts:

- If you were 9 weeks pregnant or more, it is possible to leak clear or whitish fluid (milk) from your breasts. This is a normal affect of hormones. Wear a tight supportive bra 24 hours a day and avoid breast/nipple stimulation until milk dries up. This can take up to 4 weeks.

5. Medication(s):

- Take antibiotics and other medication prescribed by your doctor completely. Start antibiotics after your surgery, preferably after you eat.

☐ Cytotec ☐Doxycycline ☐Flagyl ☐Rhogam ☐Other_____

- Take an over-the-counter pain reliever for pain if needed. Do not take aspirin.
- You may resume at home medications. **Please refer to your doctor if you have any questions about your regular scheduled medications.**

6. Birth Control Method Received: ☐Birth Control Pills ☐Depo Provera IM ☐Other_____

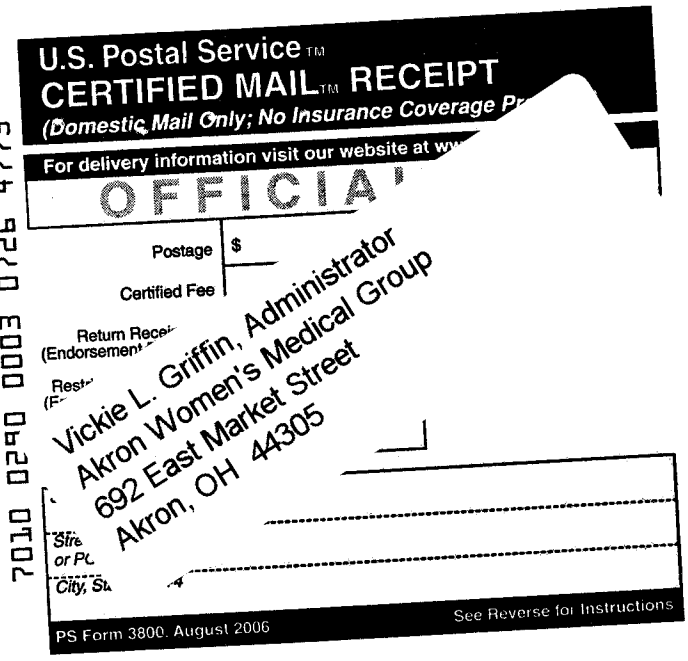
- Start _____ on _____. Remember that the first full pack will not protect you from pregnancy. Use condoms as back-up. Effectiveness of birth control pills decreases when taking antibiotics and/or having stomach sickness (diarrhea/vomiting) that interferes with pill absorption.

7. Follow-Up: It is recommended that you follow-up in 2-3 weeks after your procedure.
Please return on_____

8. Symptoms and When to Call: On-call nurse 24-hour number **216-233-3095**
▪Soaking more than one pad in 1 hour for 4-6 hours. ▪Fever over 101.0° for more than 3 days.
▪Severe abdominal pain/cramping that doesn't respond to pain medicine.
▪Foul smelling vaginal discharge. ▪Passing clots larger than a golf ball for more than 2 hours.
▪Increased bright red, heavy bleeding.

I have received all of my discharge instructions both verbally and in writing. I understand that Dr. L. Ann Nunnally or Dr. Raymond Robinson or Dr. M.H. Reese was my physician today. I hold the facility, physician and/or other employees of the facility harmless for the problems arising from my neglect in not following the instructions given above. I have read, understood, and received a copy of the above information.

Patient Signature **Discharge Nurse/Date**



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Vickie L. Griffin, Administrator
Akron Women's Medical Group
692 East Market Street
Akron, OH 44305

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Angel Woodard

C. Date of Delivery 3-26-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

e ☐ Express Mail
ed ☐ Return Receipt for Merchandise
Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. 7010 0290 0003 0726 4775

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