DOUGLAS WOMEN'S CENTER

Lisa Ortenzi, MD, FACOG
Holly Burman, MSN, WHNP
Suzanne Csorna, MSN, ANP-BC, WHNP-BC

Welcome to Douglas Women's Center! We appreciate the opportunity to serve you and look forward to meeting you.

Your appointment has been scheduled for: _____

Enclosed you will find a Registration Form, Health History Questionnaire, as well as our HIPAA Privacy Policy. **PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE.** Our goal is to keep your waiting time to a minimum and to make your visit with us as pleasant as possible.

Please complete the forms in advance and fax or mail them to our office along with a copy of the **front & back of your insurance card**. **IMPORTANT:** If you plan to mail the forms, please **allow at least 7 days** prior to your appointment to allow time for delivery. If you do not have access to a fax machine and time does not allow you to mail them, please bring all forms with you to the appointment. Our fax number is 770-739-6006.

Please arrive 20 minutes prior to your scheduled appointment time so that we may check you in and prepare your medical chart.

Payment is expected at the time of service unless prior arrangements are made. WE DO FILE INSURANCE CLAIMS FOR YOU AS A COURTESY. HOWEVER, IT IS IMPORTANT FOR YOU TO BECOME FAMILIAR WITH YOUR PARTICULAR INSURANCE BENEFITS, AS ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY.

IF YOU ARE COVERED BY INSURANCE, YOU MUST BRING YOUR CARD WITH YOU. WITHOUT YOUR INSURANCE CARD, YOU WILL BE RESPONSIBLE FOR CHARGES OR HAVE THE OPTION TO RESCHEDULE YOUR APPOINTMENT.

If for some reason you must cancel your appointment, please notify us at least ***24 HOURS*** prior to your appointment to avoid a **$35.00 cancellation fee**. This will help us utilize your time slot for other patients who may need to be seen.

We are looking forward to seeing you and we welcome any questions you may have.

Sincerely,

Lisa Ortenzi, MD, FACOG Holly Burman, MSN, WHNP

Suzanne Csorna, MSN, ANP-BC, WHNP-BC

PLEASE NOTE:

We use an automated appointment reminder system. This is an automated system which will call to remind you of your appointment between the hours of 5:00 p.m. and 9:00 p.m. **When you receive the call, please listen carefully to the message.** The automated recording will notify you of the day and time of your scheduled appointment with Douglas Women's Center. **It will not indicate who your appointment is with, nor will it indicate the type of appointment scheduled.**

If you have more than one appointment scheduled for the same day, the automated recording will give you the time of the first appointment only. For example, if you are scheduled to have a mammogram at 9:00, and an appointment with the provider at 9:30, the message will only indicate that you have an appointment with Douglas Women's Center at 9:00 a.m. on the specified date.

Please listen to the message in full and at the end, press "1" to confirm your appointment, or "2" to cancel your appointment. If you do not respond to the recording, our scheduling team will attempt to contact you a second time by phone. If you decide to cancel your appointment, our scheduling team will follow-up to see if you would like to re-schedule for a more convenient time.

IMPORTANT: If you have voice mail, the system may hang up without leaving a message and it will appear as a "missed call" from Douglas Women's Center.

07/24/2015

DOUGLAS WOMEN'S CENTER PATIENT REGISTRATION FORM

PLEASE **PRINT** CLEARLY!

Patient's Full Name: _____
FIRST MIDDLE MAIDEN LAST

Nickname or Name Patient Prefers To Be Called: _____

Street Address:_____**Lot # or Apt #**_____

City _____**State** _____ **Zip Code**_____

VERY IMPORTANT! PLEASE PROVIDE ALL CURRENT CONTACT NUMBERS WHERE YOU CAN BE REACHED:

Home Phone#: _____**Work Phone**#: _____

Cell Phone#: _____ **Any Other #'s**: _____

Social Security#: _____**Date of Birth**: _____**Marital Status** _____

Employer: _____**Employer Address:** _____

Primary Physician or Personal Physician (other than Douglas Women's Center): _____

Referred By: _____ **Allergies:** _____

INFORMATION FOR SPOUSE:

Spouse Name: _____ **Spouse Date of Birth**:_____

Employer_____ **Employer Address**: _____

Spouse Work Phone#:_____ **Spouse Cell #:** _____ **Spouse Social Security #:**_____

PLEASE PROVIDE TWO EMERGENCY CONTACTS:

1) Name:_____ Relationship To Pt. _____ Home# _____ Work# _____ Cell#_____

2) Name:_____ Relationship To Pt. _____ Home# _____ Work#_____ Cell#_____

INSURANCE INFORMATION:

Primary Insurance Co _____

Name of Primary Card Holder: _____DOB: _____Relationship to Patient: _____

Claim Mailing Address: _____

ID#_____Group#: _____

Secondary Insurance Co: _____

Name of Primary Card Holder: _____DOB: _____Relationship to Patient: _____

Claim Mailing Address: _____

ID#_____Group#: _____

PLEASE READ THE FOLLOWING STATEMENTS AND WRITE YOUR INITIALS IN THE SPACE PROVIDED:

(INITIAL) _____I authorize Douglas Women's Center, P.C., to release to my insurance company information required in the course of my treatment.

(INITIAL) _____I hereby assign payment directly to Douglas Women's Center, P.C. for medical benefits payable for these services. I understand that I am responsible for any charges not paid under this assignment and/or for any non-covered service.

_____ _____
Signature of Patient Date

_____ _____
Signature of Responsible Person if Patient is a Minor Date

Revised 02/17/12 ***(Office Use Only) Acct. #*** _____***Emp. Init.*** _____

DOUGLAS WOMEN'S CENTER **NEW PATIENT HISTORY**

Name Age Marital Status: S M D W Date

Occupation Education Medical Doctor

Referred by: **(Keep blank for Doctor's use)**

Reason for visit: (1)

(2)

(3)

MEDICAL HISTORY (Check if applicable to:)	**You**	**Family**
Headaches — Tension, Vascular, Migraine		
Nervous Disorders — Epilepsy, Encephalitis, Meningitis		
Visual Problems		
Hearing Problems		
Thyroid Problems		
Heart Condition/Rheumatic Fever		
High Blood Pressure/Stroke		
Breathing Problems/Asthma/Pneumonia		
Breast Problems — Fibrocystic breast disease/Mass		
Intestinal Problems — Ulcers/Gallbladder, Colitis/Spastic Colon/ Hepatitis		
Blood Disorder — Anemia/Bleeder/Leukemia		
Diabetes		
Cancer		
Kidney Disease/Stones/Infection/Failure		
Sexually Transmitted Disease: Herpes/Gonorrhea		
Psychiatric Disorder/Suicide/Addiction		

HOSPITALIZATIONS AND SURGERY:

Mo/Yr	Illness/Surgery	Doctor/Hospital

CURRENT MEDICATIONS:

Name	Dose

GYNECOLOGIC HISTORY:

1st day of last period: Periods are: Reg. Irreg.

Age of onset of periods: Number of days of period:

Do you have painful periods? Yes No

Do you use pads or tampons? How many per period?

Are you sexually active? Yes No

What do you use to prevent pregnancy?

Have had abnormal PAP smears? Yes No Last PAP

OBSTETRIC HISTORY:

Total number of pregnancies miscarriages/ abortions

Date	Sex	Wt.	Weeks	Type Delivery	Problems

Do you have drug allergies?

Drug	Reaction

Have you had a blood transfusion?

Do you smoke cigarettes?

Do you smoke pot?

How much alcohol do you drink?

Have you used cocaine, speed?

Have you used intravenous drugs?

ANY OTHER INFO YOU THINK IMPORTANT:

DOUGLAS WOMEN'S CENTER **NEW PATIENT**

HEALTH REVIEW (Circle if applicable)		(Leave blank for Doctor's use)
Weight	Loss Gain Usual Weight	Date
Head	Frequent headaches	
	Sinus problems	
	Visual problems Glasses	
	Dizzy spells	
	Eye diseases — Cataracts, Glaucoma	
Skin	Acne Rash	
	Worrisome moles Warts	
Neck	Enlarged thyroid, lymph nodes	
	Difficulty swallowing	
Breasts	Lumps	
	Pain	
	Discharge	
	Have you had a mammogram? When?	
Breathing	Cough	
	Shortness of breath	
Heart	Chest pain	
	Rapid heart beat	
	Fainting	
Intestines	Indigestion	
	Nausea	
	Diarrhea/Constipation	
	Hemorrhoids	
	Blood in stools	
Bladder	Frequent infections	
	Leaking urine Night Day	
Vaginal	Discharge	
	Odor	
	Itching	
Pelvic Infections	Uterus Ovaries	
Love Making	Painful Dry	
	Satisfied	
Misc.	Arthritis	
	Swelling	
	Joint or muscle pain	
	Back pain	
	Varicose veins/Phlebitis	
	Hot flashes	
	Night Sweats	
	Insomnia	
	Tiredness	
	Anxious/Nervous	
Optional:	Have had professional therapy? Yes No	
	Problems with drug/alcohol addiction?	
	Suffered sexual abuse? As child? Adult?	
	Do you want to discuss this? Yes No	
	Have you been battered? Yes No Do you want help? Yes No	

DOUGLAS WOMEN'S CENTER
Method of Contact &
Permission To Leave Health Information With Persons Other Than Patient
Authorization Form

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please note, the referring physician or referral source may be sent a copy of records to ensure continuity of care.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

Home Telephone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

Work Telephone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

Written Communication

- O.K. to mail to my home address ____
- O.K. to mail to my work/office address ____
- O.K. to fax to this number _____ ____
-

Cell Phone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

I AUTHORIZE DOUGLAS WOMEN'S CENTER TO LEAVE INFORMATION WITH THE FOLLOWING PEOPLE:

Name: Relationship:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature **Date:**

Print Name: **Social Security #:** **Birth Date:**

DIRECTIONS TO DOUGLAS WOMEN'S CENTER

880 Crestmark Drive, Suite 200
Lithia Springs GA 30122

From Atlanta:

I-20 West to Thornton Road exit #44 – turn right off ramp.
Go to second traffic light turn left onto Skyview Drive
Turn left at first street onto Crestmark Drive
Go around curve to last building on left, 880 Crestmark Dr., Suite 200 (upstairs)
(second light gray building with blue roof behind Shoney's Inn & McDonalds)

Toward Atlanta:

I-20 east to Thornton Rd exit #44 – turn left off ramp
Go to third traffic light turn left onto Skyview Drive
Turn left at first street onto Crestmark Drive
Go around curve to last building on left, 880 Crestmark Dr., Suite 200 (upstairs)
(second light gray building with blue roof behind Shoney's Inn & McDonalds)

If you have any problems locating our office, please call 770-941-8662

To: All Patients of Douglas Women's Center

From: Patricia H. Holloway, Administrator

Re: Change in policy due to HIPAA Compliance

I would like to take this opportunity to thank you for being an important patient of Douglas Women's Center. We appreciate you and look forward to providing medical services to you for many years. We are proud of our outstanding providers and support staff members who offer excellence in patient care.

To assure privacy for all, we have had to modify our policies.

1) To insure HIPAA compliance, Douglas Women's Center discourages guests due to space limitations and maintaining the privacy of others. The front desk receptionist will no longer guide guests to the back areas. Guests must stay with the patient at all times. No exceptions, unless there is an emergency situation.
2) Children must be supervised in the lobby area while the patient is being seen by the doctor.

We welcome your questions or comments and continue to seek the best in healthcare and courtesy for our patients.

Sincerely,

Patricia H. Holloway
Administrator
Phone Number 770-941-8662

DOUGLAS WOMEN'S CENTER
NOTICE OF PRIVACY PRACTICES
REVISED APRIL 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT ANY PART OF THIS NOTICE, PLEASE ASK TO SPEAK TO OUR PRIVACY OFFICER.

This notice of Privacy Practices describes how we may use and disclose your protected health information needed to treat you, obtain payment for services, for health care operations and for other purposes permitted by law. The term "protected health information" means any information about you, including information that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

The practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is required to comply with the terms of this Notice of Privacy Practice.

This Notice of Privacy Practices will apply to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

CHANGES TO OUR NOTICE OF PRIVACY PRACTICES

The practice may change the terms of this Notice at any time. The new notice will be effective for all protected health information that we maintain at that time with the last revision date in the lower left corner. The current notice will always be posted in our office and on our practice website (www.douglaswomenscenter.com). To request a revised Notice or Privacy Practices you may:

1. Call the office at 770-941-8662 and request a copy be sent to you at your mailing address, or e-mail address
2. Ask for a copy at your next visit to our office, or
3. Open our website and read and/or print a copy of the current Notice

OUR COMMITMENT TO YOU:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. You should be comfortable in sharing any information about your health with your doctor in order to help him/her provide the most appropriate health care. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

All of our medical and administrative staff understands that the practice is required by law to:

- make sure that the protected health information about you is kept private;
- provide you with Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

HOW YOUR MEDICAL INFORMATIONS MAY BE USED OR DISCLOSED

We will use your medical information as part of rendering patient care. This explanation is provided only to help you understand how the practice may use or disclose your protected information in compliance with any authorizations or consents required by law. For example, your medical information may be used for:

Medical Treatment. We will use medical information about you that was on file prior to this notice or which may be obtained after this the date of this Notice to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with others that have already obtained your permission to have access to your protected health information. Therefore, we may disclose medical information about you to other doctors, nurses, laboratory or imaging technicians, medical students, hospital or home health personnel who are involved in taking care of you. We may also disclose information to other doctors who may be treating you or to who we may refer you for care.

Different areas of our practice also may share medical information about you including your record(s), prescriptions, requests for lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside our practice who may be involved in your medical care after you leave the practice; this may include your family members, or other personal representatives authorized **by you or by a legal mandate** (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

There will be occasions that we may have to provide health insurance information regarding disability, return to work evaluation, pre-certifications, eligibility, etc.

Douglas Women's Center will speak directly with the patient regarding medical advice or medical care. Your medical situation will not be discussed with other family members unless there is an emergency.

Payment. We may use and disclose medical information about you to your insurance company or third party payor for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Health Care Operations. We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. When business associates are used, we will advise them of their continued obligation to maintain the privacy of your medical records.

Appointment and Patient Recall Reminders. We may ask that you sign in at the Receptionists' Desk, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving of an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others. **Please let us know, in writing, if this is not acceptable or if there is another telephone number, e-mail address, or method of notification you prefer.** Staff will not relay messages of any nature unless there is a medical emergency determined by your provider. We will not confirm that you are present as a patient to family members that may call.

Protected Privacy During Visits. On the date of your appointment, staff will not take an incoming call message from for you unless there is a dire emergency. Nor will we confirm your presence if someone stops by the office and asks for you.

Emergency Situations & Disaster Relief. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for use or disclosure is not required.

Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities. We may disclose medical information to a local state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health issue. We may also disclose medical information about you in response to subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office administrator, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

The Office administrator can be reached at this number: 770-941-8662.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

The privacy officer of Douglas Women's Center can provide information regarding release activity of your medical records if you so desire. This information can be obtained within 7 days of the written receipt of your request.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Privacy Compliance Officer. Ask the front desk person for the name of the Privacy Compliance Officer. If you request a copy of information, we may charge a fee for the cost of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from the review.

- **Right to Amend**. If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

  To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  2. Is not part of the medical information kept by or for the Practice;
  3. Is not part of the information which you would be permitted to inspect and copy; or
  4. Is inaccurate and incomplete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures" made by this practice after April 14, 2003. This is a list of the disclosures we made of medical information about you to others that are not involved with your treatment, payment of services rendered to you or health care operations as previously defined in this Notice of Privacy Practices.

  To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, or electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will make every effort to respond within 7 working days.

- **Right to Request Restrictions**. You have the right to request a restriction or limitations on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

  We are not required to agree to your request and may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

  To request restrictions, you must make your request **in writing**. In your request, you indicate:

  1. what information you want to limit;
  2. whether you want to limit our use, disclosure or both; and

3. to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

  To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- **Other**. Douglas Women's Center will speak directly with the patient regarding medical advice or medical care. Patients should not request that family members or other individuals communicate with our staff to request prescription or treatment plans unless there is a crisis. Exceptions to this include emergency situations such as might occur following surgery, hospitalization, emergency room visits or situations that the provider deems as an emergency. In such instances, it may be necessary to discuss a patient's medical situation directly with or in the presence of a family member or other individuals who are present.

- **Visitors.** Visitors who accompany patients to the office must sign-in at the front desk and shall not enter any areas marked "Authorized Personnel Only." Visitors must maintain the privacy of the patient, as well. Due to limited space in our waiting area, we ask that patients limit visitors to only those who are offering assistance to the patient whenever possible.

The Doctors and Staff of Douglas Women's Center Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA'). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and others healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager/Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of Douglas Women's Center's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: _____
(Please Print)
Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:
_____

YOU WILL BE ASKED TO SIGN A COPY OF THIS ON YOUR NEXT APPOINTMENT.
THIS COPY IS FOR YOUR RECORDS.