ADVANCED Women's HEALTH CENTER

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME:_____
DOB: _____ SSN#_____
MAILING ADRESS:

_____

CITY: _____STATE: _____ ZIP:_____
**PLEASE FILL OUT ALL THE NUMBERS AND EMAILS INFORMATION. FOR PRIVACY REASONS, PLEASE LET US KNOW IF WE CAN LEAVE DETAILED INFORMATION ABOUT YOUR LAB RESULTS ON YOUR VOICEMAIL. **

CIRCLE: YES OR NO ( ) HOME OR CELL ( ), PATIENT SIGNATURE: _____
HOME#: _____-_____ CELL NUMBER: _____-_____
EMAIL: _____@_____ FAX NUMBER: _____-_____

PHARMACY NAME/ ADDRESS/NUMBER:

_____

EMPLOYER INFORMATION:
OCCUPATION: _____ WORK NUMBER: _____-_____
EMERGENCY CONTACT:
NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE NUMBER: _____- _____

PRIMARY CARE PHYSICIAN
NAME: _____ PHONE NUMBER: _____-_____
REFERRED BY: _____

INSURANCE INFORMATION/GUARANTOR:

GUARANTORS NAME: _____ DOB: _____
PRIMARY INS. NAME: _____ ID#: _____
INSURED NAME: _____ INSURED DOB: _____ INSURED SS#_____
SECONDARY INS. NAME: _____ ID# _____
INSURED NAME: _____ INSURED DOB: _____ INSURED SS#_____
RELATIONSHIP TO INSURED: ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER
WOULD YOU LIKE A COPY OF AN ADVANCED DIRECTIVE? ( ) YES ( ) NO

Department of Obstetrics and Gynecology

PATIENT HISTORY QUESTIONNAIRE

A

1. Marital Status: ☐ Single ☐ Married ☐ Long term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: _____
3. Referring Physician: _____
4. Occupation: _____
5. Preferred phone number: _____ confidential voice mails OK: ☐ Yes ☐ No
6. Partner: _____ ☐ None 7. Age of partner: _____
   last first 8. Occupation of partner: _____

B MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

7. Age at first period: _____ years.
8. If your menstrual periods are regular; periods start every: _____ days
9. If your menstrual periods are irregular; periods start every: ____ to ____ days (e.g.,12 to 60)
10. Duration of bleeding: _____ days
11. Does bleeding or spotting occur between periods? Yes ☐ No ☐
12. Does bleeding or spotting occur after intercourse? Yes ☐ No ☐
13. First day of last menstrual period _____
    month day year
14. Is pain associated with periods? Yes ☐ No ☐ Occasionally ☐
15. If yes to 14, is it: before menses? ☐ during menses? ☐ both? ☐

C PREGNANCY HISTORY (All pregnancies) Have never been pregnant ☐

16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of delivery or Abortion	Duration Preg.	Hrs. of Labor	Type of Delivery	Complications Mother and/or Infant	CHILD		
						Sex	Birth Weight	Present Health

D BIRTH CONTROL HISTORY

17. What birth control method(s) do you currently use? _____

E SEXUAL HISTORY

18. Do you have a sexual partner? No ☐ Yes ☐ (Male ☐ Female ☐)
19. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes ☐ No ☐

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

20. Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR
☐ D&C		☐ ovarian surgery	
☐ hysteroscopy		☐ L cyst(s) removed ovarian	
☐ infertility surgery		☐ R cyst(s) removed ovarian	
☐ tuboplasty		☐ L ovary removed	
☐ tubal ligation		☐ R ovary removed	
☐ laparoscopy		☐ vaginal or bladder repair for prolapsed or incontinence	
☐ hysterectomy (vaginal)		☐ cesarean section	
☐ hysterectomy (abdominal)		☐ other (specify) _____	
☐ myomectomy			

G PAST SURGICAL HISTORY (Not OB/GYN)

21. List all surgeries and their year or ☐ None

Surgeries	Year

H PAP SMEAR/MAMMOGRAM HISTORY

22. ☐ Date of last pap smear: _____
23. ☐ Have you had abnormal pap smears? No ☐ Yes ☐
24. ☐ Have you had treatment for abnormal smears? No ☐ Yes ☐

If yes, what type(s) of treatment have you had?

	YEAR
cryotherapy	
laser	
cone biopsy	
loop excision (LEEP)	

25. Date of last mammogram: _____ (month) _____ (year)
26. Have you had an abnormal mammogram? No ☐ Yes ☐

OTHER PAST GYNECOLOGICAL HISTORY

27. Check any that apply: ☐ None ☐ Venereal warts ☐ Herpes – genital ☐ Syphilis ☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea ☐ Vaginal infections ☐ Other _____

I PAST MEDICAL HISTORY Check any that apply: or ☐ None

☐ Arthritis
☐ Diabetes:
  ☐ Diet controlled
  ☐ Pill controlled
  ☐ Insulin controlled
☐ High blood pressure
☐ Heart disease
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder
☐ Other: _____

J CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

K DO YOU CURRENTLY?:

28. Smoke No ☐ Yes ☐ _____ packs/day
29. Use alcohol No ☐ Yes ☐ __ wine (glasses/day); __ beer (bottles/day); __ hard liquid (oz./day)
30. Use illicit drugs No ☐ Yes ☐ _____ type _____ amount
31. Exercise: Type: _____ How often _____

L DRUG ALLERGIES

32. No ☐ Yes ☐ List:

_____

_____

_____

M FAMILY HISTORY

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other
☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer _____
_____

If "yes" to any, please list affected relatives

_____ _____

_____ _____

☐ None of the above.

N OTHER SYMPTOMS

Have you had recent?:

- ☐ weight loss
- ☐ weight gain
- ☐ change in energy
- ☐ change in exercise tolerance
- ☐ hair growth
- ☐ hair loss
- ☐ change in urinary function
- ☐ hot flushes/flashing
- ☐ breast discharge
- ☐ none of the above
- ☐ Other _____

O

Note: Fill out Section "O" only if you are pregnant or planning to be pregnant in the near future.

Have you or the baby's father or anyone in your families ever had any of the following:

- ☐ Down Syndrome (Mongolism)? If yes, who? _____
- ☐ Other Chromosomal abnormality? If yes, specify _____
- ☐ Neural tube defect (spina bifida, anencephaly)? If yes, who? _____
- ☐ Hemophilia or other coagulation abnormality? If yes, who? _____
- ☐ Muscular Dystrophy? If yes, who? _____
- ☐ Cystic Fibrosis? If yes, who? _____
- ☐ If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
  - ☐ Father Result _____
  - ☐ Mother Result _____
- ☐ If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?
  - ☐ Father Result _____
  - ☐ Mother Result _____
- ☐ If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalessemia?
  - ☐ Father Result _____
  - ☐ Mother Result _____
- ☐ If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?
  - ☐ Father Result _____
  - ☐ Mother Result _____

_____ _____ _____

PATIENT SIGNATURE DATE TIME

_____ _____ _____

PHYSICIAN SIGNATURE DATE TIME

ADVANCED Women's HEALTH CENTER

PATIENTS RIGHTS AND RESPONSIBILITIES

Quality healthcare is the result of you, the patient, working closely with your healthcare providers. Knowing and exercising your rights and responsibilities will result in optimal healthcare outcomes. The following statement of your rights and responsibilities is presented as the policy of Advanced Women's Health Center but does not presume to be a complete representation of all mutual rights and responsibilities.

PATIENT RIGHTS:

- You have the right to receive considerate, respectful, and compassionate care regardless of your age, gender, race, national origin, religion, sexual orientation, or disabilities.
- You have the right to receive care in a safe environment free from all forms of abuse, neglect, or harassment.
- You can expect full consideration of your privacy and confidentiality in all communication, care discussions, examinations, and treatment. You may ask for a chaperone during any type of examination.
- You have the right to approve or refuse the release of your medical records, except when release is required by law.
- You can expect full confidentiality of your disclosures and medical records concerning your care with respect to your privacy. Right to access the information contained in your medical record and the information in the medical record explained to you by a qualified staff member or your provider.
- You have the right to be told by your provider about your diagnosis and possible prognosis, the risks, benefits, and alternatives to treatment, including unanticipated outcomes. You have the right to give written informed consent before any non-emergency procedure begins.
- You have the right to make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
- You have the right to refuse treatment to the extent provided by law and to be informed of the consequences of refusal. When refusal of treatment prevents Advance Women's Health Center from providing appropriate care according to ethical and professional standards, the relationship with you may be terminated upon reasonable notice.
- You have the right to consent or refuse experimental treatment and not to participate in research unless consent is given.
- You have the right to access our website www.advancedwomenshealthcenter.com for all services provided at our office.
- You have the right to be informed of fees for services and payment policies before services are rendered.
- You have the right to change providers if other qualified providers are available.
- You have the right to review the credentials of the physicians and healthcare providers involved in your care.
- You have the right to accurate information regarding services at Advanced Women's Health Center.
- You have the right to voice your concerns about the care you receive. For expressing suggestions, complaints, or grievances, you may do so in writing or call the office manager at Advanced Women's Health Center, 8501 Brimhall Rd. #300, Bakersfield, CA 93312, (661) 410-2942. To file a complaint with the state Department of Public Health regardless of whether you use Advance Women's Health Center's grievance process. The state Department of Public Health's phone number and address is: 1200 Discovery Plaza #120, Bakersfield, CA 93309, (661)336-0543 or (866)222-1903.

To ensure that we provide you with the highest quality healthcare, this is what our expectations are from you:

PATIENT RESPONSIBILITIES:

- You are expected to conduct yourself in an appropriate manner and comply with your responsibilities as a patient. Be respectful of all healthcare providers and staff, as well as other patients.
- You should provide a copy of your advanced directive to you provider if you have one, as required by state or federal law and regulations. Inform your provider if you have a living will, medical power of attorney, or other directive that could affect your care.
- You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, social security number, insurance carrier and employer, when it is required.
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, surgeries, medicines, vitamins, herbal products, allergies or sensitivities, and any other matters that pertain to your health, including perceived safety risks.
- You are expected to follow the plan of care prescribed by your provider for your treatment. You are responsible for the outcomes if you do not follow the care, treatment, and services plan.
- You are expected to ask questions when you do not understand information and/or instructions. If you believe that you can't follow through with your treatment plan, you are responsible for telling your provider.
- You are expected to notify your provider if there is a change in your condition. If you are in need of urgent or emergency care after office hours, you are expected to report to an urgent care or emergency room for care and follow up in office as directed.
- You are expected to provide a responsible adult to transport you home from Advanced Women's Health Center and remain with you for 24 hours if required by your provider.
- You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner, also accept personal financial responsibility for any charges not covered by your insurance.
- You are expected to keep and be on time for your appointments, or to notify the office if you cannot keep your appointment.
-
-

Name: _____ Signature _____ Date: _____

ADVANCED Women's HEALTH CENTER

We are honored you have chosen us for you OB/GYN needs. In order to keep a completely professional and up front business relationship with our patients, we ask that you read and state that you understand our payment policy and our insurance policy. If you do not have medical insurance please skip down to the bottom of the page.

PATIENT FINANCIAL RESPONSIBLILITY AGREEMENT

I understand that my insurance policy is a contract between my insurance company and myself. The contract is not between Advanced Women's Health Center and my insurance company. I know that I am fully responsible for all charges resulting from services rendered to me and all balances remaining after possible payment from insurance benefits. As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payments amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the day the services are rendered, including co-payments and deductibles. However, if payment from your insurance company is not received within 30 days we will notify you of the balance due and your payment is expected in full at that time.

I understand that should my account become delinquent, I will be legally responsible for all cost involved with the collection of this account including all court cost, reasonable attorney fees and all other related cost as allowed under California law including any interest accumulated.

In addition to the office fees, there may also be additional fees, specimen handling fees, medical supplies, pap smears, biopsy, cultures, blood test, and ultrasounds. More than one laboratory may be used to analyze your laboratory tests. Even though your insurance will be billed, you may receive bills from the outside laboratories, and/ or our medical office/laboratory separately.

Again, please note those laboratories and ultrasound charges are separate from office visit, consults and/ or other procedures performed here in the office.

" I HAVE BEEN NOTIFIES BY MY PHYSICIAN/PROVIDER, THAT PAYMENT MAY BE DENIED, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT, AND AGREE TO MAKE SUCH PAYMENTS."

Please review and initial below.

____**Cancellation/No Show Policy**

While understanding there may be times when you miss an appointment due to emergencies or obligations, our office requires at least 24 hours notice on all cancelled appointments. Our office charges a fee of $25.00 for appointments not cancelled or rescheduled 24 hours in advance. Cancellation/no show fees must be paid prior to you next appointment.

____ **Form Completion Policy**

There is initial fee of $25.00 for all completed forms. If any additional forms need to be completed there is a $5.00 fee per form. All forms are completed within 7-10 business days. If you request forms to be completed within 48 hours there is an additional fee of $10.00. All forms must be paid in full at time of drop off.

____ **Insurance Authorization/Release:**

I herby authorize the physician/provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

My signature below indicates that I have read and understood the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required processing claims and benefits to which I am entitled.

Patient Name Printed: _____ SIGNATURE: _____ DATE: _____

ADVANCED Women's HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but not describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes that coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to home health agency that provides care to you. We will also disclose protected health information to other physician who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you. In addition, we may disclose our protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates' that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use of disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child/elderly abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable products recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and other wise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend and individual.

Workers' Compensation: We may disclose your protected health information as authorized to comply with worker' compensation laws and other similar legally established programs.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

OTHER PREMITTED ANDREQUIRED USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician/provider may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your provider and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact of Office Manager if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. You may request a restriction by writing.

This notice was published and becomes effective on January 1, 2010.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Office Manager, Viridiana Zuniga at 661-410-2942 or vzuniga@awhc.info for further information about the complaint process.

This notice was published and becomes effective on January 1, 2010.

I have read and understand the Notice of Privacy Practices regarding my protected health information and have received a copy if requested.

_____ _____

Print Name Date of Birth

_____ _____

Patient's Signature Date

ADVANCED Women's HEALTH CENTER

I, _____, have disclosed any and all insurance plans that I hold. I am aware if I do not disclose any and all insurance plans that I hold, I will be held responsible for any incurred charges that my insurance denies or any other charges that are not paid by my insurance.

I, _____, acknowledge that I have only the following insurance plan or plans

1. _____
2. _____
3. _____

I understand and agree that (regardless of whatever health insurance or medical benefit I have), I am ultimately responsible to pay Advanced Women's Health Center, provider, the balance due on my account for any testing or professional services rendered and for any supplies or medications provided.

Date: _____

Patient Name_____

Patient Signature_____

Social Security Number_____

Witness Signature_____