PATIENT INFORMATION

Patient Name: Last: ______________________________First: _____________________________ Middle: ________________

Address: ____Home Phone: ________________________

City: __________________________________ State: _______ Zip: _____________Cell Phone: ________________________

Date of Birth: _________________Social Security#: _________________________Email: ____________________________

Check one: ____Single ____Married ____Divorced ____Widowed ____Separated

Patient's Employer: ____Occupation: ________________________________

Employer Address: ____Work Phone: ________________________

City: ____ State: ________________ Zip: ___________________________

Worked-related Injury: __Yes __No Automobile Accident: __Yes __No Date of Injury/Accident: ____________

Emergency Contact: _____________________________Relationship: ________________Phone: _______________________

Advanced Directive: __Yes __No Copy on File: __Yes __No Retired: __Yes __No

Referred by: ____

POLICY HOLDER/INSURED INFORMATION - Primary Insurance

Relationship to Patient: __Self __Spouse __Mother __Father __Other: ____________

Insured Name: ____Phone: _________________________

Address: ____City: __________________ State: ______ Zip: __________

Date of Birth: _______________________________________Social Security#: ____

Employer: ____________________________Employer Address: ____

City: _________________________________ State: _______ Zip: ___________Work Phone: _________________________

Primary Insurance: ____Phone: _________________________

Group#: ____Policy#: ____

INSURANCE COMPANY INFORMATION- Secondary Insurance

Relationship to Patient: __Self __Spouse __Mother __Father __Other: ____________

Insured Name: ____Phone: _________________________

Address: ____City: __________________ State: ______ Zip: __________

Date of Birth: _______________________________________Social Security#: ____

Secondary Insurance: ____Phone: _________________________

Group#: ____Policy#: ____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Galleria Women's Health. I understand that payment for copays and deductibles are required at the time services are rendered. I further understand that I am responsible for the payment of services rendered by Galleria Women's Health. In the event that my insurance company denies a claim, I will become responsible for all amounts not covered payable to Galleria Women's Health. As a parent/guardian, I am financially responsible for services rendered to a minor. If my account is turned over for outside collections, I will be responsible for all costs of the outside collection agency. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary.

SIGNATURE: ____ Date: __________________________

Galleria Women's Health

Patient Contact Information

Patient Name: ____________________________________ Date of Birth: ________________________

To be HIPPA compliant we need you to tell us how to contact you with your health information. You need to be very specific regarding how you prefer to be contacted and where we can leave clinical messages and tests or lab results.

How do you prefer to be contacted? (ONLY INDICATE YOUR PREFERENCE)

Cell Phone: ________________________________ Patient Portal: ______________________________

Work Phone: _______________________________Home Phone: ______________________________

Are we able to leave personal clinical, medical or lab results messages? ______Yes ______No

(YES) I hereby give Galleria Women's Health permission to leave clinical/medical messages, which may include personal and sensitive information on the media source(s) that I have indicated above. I understand that is my responsibility to keep my contact information updated.

Signature: ____ Date: ___________________

(NO) I only consent for Galleria Women's Health to leave a general call back message for me. **I understand that it is fully my responsibility to return all calls in a timely manner**. I understand that is my responsibility to keep my contact information updated.

Signature: ____ Date: ___________________

If you are unavailable, is there anyone that you give us permission to leave such messages with?
_____Yes _____No

If yes, provide their name, relationship to you and contact information.

Name: ___________________________ Relationship: __________________ Phone: _______________

Pharmacy of Choice: _________________________ Pharmacy Phone: ___________________________

Pharmacy Cross Streets: ____

MEDICAL HISTORY FORM

Today's Date: _______________

Patient Name: ____

Date of Birth: __________________ Age: ______ Primary Care Physician: __________________________

Medication Allergies: ____
____

Please List the reason(s) for your appointment today: ___________________________
____
____

Duration: ____

Obstetrical History

Total pregnancies: _______________ Vaginal: _____________ Cesarean: _______________

Total Children: ________________ Full Term: ____________ Pre-Term: _______________

Abortions: ___________________ Miscarriages: __________ Ectopic: _________________

Gynecology History

When was your last Pap Smear? ________________ History of Abnormal Pap: __Yes __No

When was your last mammogram? ______________ History of Abnormal Mammogram: __Yes __No

When was you last Dexa Scan? ________________ History of Abnormal Dexa: __Yes __No

When was your last colonoscopy? ______________ History of Abnormal Colonoscopy: __Yes __No

Menstrual History

When was your last menstrual period? ___________________________

Your age at first menstrual period? ___________________________

Are your menstrual periods regular or irregular? ___________________________

How often are your periods? ___________________________

How many days do your periods last? ___________________________

Menstrual flow: __Light __Moderate __Heavy

Do you have cramps with your periods? __Yes __No

If yes, do you need medication for relief? __Yes __No. If yes, what medication? ____________________

If you are not having menstrual periods, at what age did you have your last one? __________________

Since menopause, any vaginal bleeding? __Yes __No

Do you have hot flashes or vaginal dryness? __Yes __No

Sexual History

How many lifetime sexual partners have you had? ___________________________

Are you sexual active at the present time? ___________________________

Do you usually have pain with Intercourse? ___________________________

What do you use for birth control? ___________________________

Have you been physically or sexually abused? ___________________________

History of any of the following sexually transmitted diseases?

___Trichomonas ___Gonorrhea ___Herpes ___PID ___Chlamydia ___Syphilis ___HIV

1389 Galleria Dr., Ste 220 • Henderson, NV 89014 • 1-702-983-2010 • Fax (702) 476-9202
Email: info@galleriaobgyn.com Website: www.galleriawomenshealth.com

Past Medical History

Have you ever had any of the following problems?

General
Cancer ___Yes
Weight gain ___Yes
Weight loss ___Yes
Fatigue ___Yes

Eyes
Glaucoma ___Yes

ENT/Mouth
Hearing loss ___Yes
Sinus Problem ___Yes
Dental Problems ___Yes

Cardiovascular
Hypertension ___Yes
Heart Attack ___Yes
Heart Palpitation ___Yes
Heart Murmur ___Yes

Musculoskeletal
Arthritis ___Yes
Osteoporosis ___Yes

Respiratory
Asthma ___Yes
Emphysema ___Yes
Bronchitis ___Yes
Tuberculosis ___Yes
Valley Fever ___Yes
Pneumonia ___Yes

Gastrointestinal
Diarrhea, frequent ___Yes
Ulcers ___Yes
Jaundice/hepatitis ___Yes
Constipation ___Yes
Diverticulosis/itis ___Yes

Breast
Tumor/cyst (benign) ___Yes
Nipple Discharge ___Yes

Psychiatric
Anxiety ___Yes
Depression ___Yes

Urinary
Incontinence ___Yes
Kidney Stone ___Yes
Blood in urine ___Yes
Urgency ___Yes
Infections, frequent ___Yes

Neurological
Seizures ___Yes
Stroke ___Yes
Headaches ___Yes

Endocrine
Thyroid Disease ___Yes
Diabetes ___Yes
Hair Growth ___Yes

Hematological
Bleeding/bruising ___Yes
Anemia ___Yes
Blood transfusion ___Yes

Any other medical condition not listed: ______________________________

Medications: Include dosages and any over the counter medications.

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Past Surgical History: List ALL operations:

Year: Type of Operations:

________ ______________________________
________ ______________________________
________ ______________________________
________ ______________________________

Social History:

Marital Status: __________ Occupation: ______________ Previous Occupation: ______________
Tobacco: __________ Alcohol: __________ Drug Abuse: __________ Exercise: __________ # in household _________

Family History: Do you have any close relatives with the following problems?

Breast Cancer: ______ Yes. Who? ______________________________
Ovarian Cancer: ______ Yes. Who? ______________________________
Colon Cancer: ______ Yes. Who? ______________________________
Diabetes: ______ Yes. Who? ______________________________
Heart Disease: ______ Yes. Who? ______________________________
High Blood Pressure: ______ Yes. Who? ______________________________
Stroke: ______ Yes. Who? ______________________________

Patient Signature:______________________________ Date: ______________

GALLERIA WOMEN'S HEALTH

HEREDITARY CANCER FAMILY HISTORY INFORMATION

Patient Name: ____ Date of Birth: ____________________

INSTRUCTIONS: Please indicate your family's history of cancer in the table below. Check **YES** for the cancer(s) that apply to you and/or your blood relatives. Please list the relative, side of the family, and age of diagnosis for each cancer type.
Blood relatives to consider: parents, children, siblings, half-siblings, aunts, uncles, cousins, nieces, nephews and grandparents.

Patient / Family Cancer History

Please fill in as completely as possible		**Your Age at Diagnosis**	**Family Member**	**Side of the Family Mother or Father's**	**Age at Diagnosis**
Example: *Breast*	*_X_Yes ___No*	*53*	*Mother* *Grandmother* *Aunt*	*-* *Mother's* *Father's*	*65* *62* *55*
Breast (one breast)	___Yes ___No				
Breast (both breasts or multiple primary breast cancers)	___Yes ___No				
Was the breast cancer triple negative?	___Yes ___No ___Unknown **Who:**				
Ovarian (Fallopian Tube, Peritoneal)	___Yes ___No				
Pancreatic	___Yes ___No				
Prostrate	___Yes ___No				
Uterine (endometrial)	___Yes ___No				
Colorectal	___Yes ___No				
Stomach	___Yes ___No				
Other – please specify Examples of other cancers: melanoma, kidney/urinary tract, brain or small bowel	___Yes ___No				

Are you of Ashkenazi Jewish descent? ___ YES ___ NO

Have you or any of your family members had genetic testing for any hereditary risk of cancer? ___ YES ___ NO

If YES, please explain: ____

______________________ ______________________ ______________________
Patient's Printed Name Patient's Signature Date

______________________ ______________________ ______________________
Guardian Relationship Date

Galleria Women's Health

GENITOURINARY SYNDROME OF MENOPAUSE EVALUATION FORM

Patient Name: ____ Date of Birth: ____________________

INSTRUCTIONS: Please indicate if you have any of the following symptoms or observations:

Feminine		**Urinary**		**Sexual**	
Vaginal Dryness	___Yes	Incontinence	___Yes	Loss of Libido	___Yes
Vaginal Irritation / Burning	___Yes	Increased Frequency	___Yes	Loss of Arousal	___Yes
Vaginal Laxity	___Yes	Urinary Urgency	___Yes	Lack of Lubrication	___Yes
Vaginal Pain / Pressure	___Yes	Postvoid Dribbling	___Yes	Difficult or Painful Sex	___Yes
Vaginal Discharge	___Yes	Blood in Urine	___Yes	Painful Orgasm	___Yes
Vaginal Tenderness	___Yes	Painful Urination	___Yes	Pelvic Pain	___Yes
		Recurring Urinary Tract Infection	___Yes	Bleeding or Spotting during intercourse	___Yes

_____________________ _____________________

Patient's Signature Date

AESTHETIC INTEREST

Patient Name: ____ Date of Birth: ____________________
Email Address: ____

Are you interested in anti-aging procedures? ___YES___NO

Skincare/Feminine Health Concerns:

FACE/SKIN		VAGINAL REJUVENATION		HAIR	
Crows Feet	___Yes	Vaginal Incontinence	___Yes	Hair Loss	___Yes
Laugh Lines/Folds around Mouth	___Yes	Vaginal Laxity	___Yes	Thinning Hair	___Yes
Wrinkles/Fine Lines	___Yes	Vaginal Dryness	___Yes		
submental Fat (Double-Chin)	___Yes				

I am interested in the following treatments/procedures::

FACE/SKIN		VAGINAL REJUVENATION		HAIR	
Peels/Facials	___Yes	ThermiVA	___Yes	Hair Loss Treatment	___Yes
Wrinkle Treatment/Skin Tightening	___Yes	Labiaplasty	___Yes		
Scar/Stretch Marks treatment	___Yes	Improved Appearance	___Yes		
Non-Surgical Lip Augmentation	___Yes	Improve Leakage	___Yes		
Non-Surgical Neck Lift	___Yes	Improve Sexual Experience	___Yes		
Non-Surgical Facelift	___Yes				

_____ I am not sure. I would like to learn more and consult with an Aesthetician to discuss treatment options.

If you could enhance one thing about your skin or beauty what would it be:_________________________________

____

_________________________ _________________________
Patient's Signature Date

SERVICE AGREEMENT

Name of Patient: ______________________________ **Date of Birth:** ____________________

Consent to Treat:

I, ____ authorize the doctors at
(Printed Name of patient or legal guardian if patient is a minor)
Galleria Women's Health to provide medical care reasonable by today's standards.

Payment for Services Rendered:
I realize that I am responsible for payment of all medical services rendered to me and/or my dependent regardless of the decisions made by my insurance carrier.

Information Release Form:
I authorize Galleria Women's Health 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 insurance payment directly to Galleria Women's Health for any services rendered that are not paid by me.

____ ____________________
Patient or Legal Guardian Signature Date

Authorization to Treat Minors:
As the parent/guardian of ____, I hereby give permission to Galleria Women's Health to evaluate and treat my child, who is a minor. I also give my permission to evaluate and treat in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to Galleria Women's Health for the charges of medical services rendered

____ ____________________
Patient or Legal Guardian Signature Date

FINANCIAL AGREEMENT

Thank you for choosing Galleria Women's Health. Please recall that your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you. We will submit an insurance claim on your behalf if we have a provider contract with your insurance company. **Please read the following agreement carefully, then sign and date below**.

______ • **All co-payments, deductibles and co-insurances are due at the time of service**. Payments can be made with cash, debit or credit cards. **Personal checks are not accepted**.

______ • I understand that not all services are covered by my insurance. **Fees for NON-COVERED care; such as the cosmetic vulvo-vaginal surgeries, Botox®, Fillers, ThermiVa, etc., are due in full at or before the time of service unless prior arrangements have been made**.

______ • **I understand that if I do not inform my doctor of ALL of my insurances (ex. primary and secondary insurances), I will be responsible for all refunded payments requested from my doctor by my insurances**.

______ • I understand that my doctor will bill my insurance company if they are contracted providers. If payment is not received from my insurance company 90 days from the date of billing, I am financially responsible for any and all services rendered.

______ • I understand that there is a **$40.00** fee to have each of my **Disability or FMLA form(s)** completed.

______ • I understand that **if I do not cancel my appointment at least 24 hours prior to the scheduled time, I will be charged a $25 fee for office visits, $75 fee for ultrasound and a $150 fee for procedures, including surgeries**. I understand that these charges are not billed to my insurance and will be charged to my credit card/debit card on file.

______ • I understand that **all labs and radiology services will be charged separately from Galleria Women's Health.**

______ • I hereby assign to Galleria Women's Health any insurance benefits available for health care services provided to me. If these benefits are not assigned to the doctors, I agree to forward all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

______ • **If this account is turned over to a collection agency**, I agree to pay the collection and legal fees necessary to collect the balance, including **a fifty percent (50%) charge** for collection services added to the unpaid balance.

______ • I have read the above statements and have no questions.

______________________	______________________	______________________
Patient's Printed Name	Patient's Signature	Date
______________________	______________________	______________________
Legal Guardian	Relationship	Date

1389 Galleria Dr., Ste 220 • Henderson, NV 89014 • 1-702-983-2010 • Fax (702) 476-9202
Email: info@galleriaobgyn.com Website: www.galleriawomenshealth.com

GALLERIA WOMEN'S HEALTH

NO SHOW / LATE CANCELLATION POLICY AND FEE

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment in a timely manner, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Ultrasounds: For our patient's convenience, we are able to schedule ultrasounds in our office. However, scheduling your ultrasound requires us to book an ultrasound technician to come to our office and be available for the scheduled times. A late cancellation or no show results in direct costs of the ultrasound technician.

Surgeries: Scheduling your surgery requires significant coordination between the hospital or surgery center, your insurance company, anesthesiologist and first assist, if applicable. A late cancellation or no show creates significant disruption.

Therefore, in order to continue to better utilize available appointments for our patients in need of medical care, we strictly enforce the following No Show / Late Cancellation Policy. **Please read the following agreement carefully, fill in the required information, and then sign and date below**.

______ • I understand that if I do not cancel my scheduled appointment (as detailed below), I will be charged a late fee (also detailed below), which is not billed to my insurance:

- **$25.00** for an **office appointment**, if I do not cancel at least **24 hours** prior to my scheduled appointment.
- **$75.00** for an **ultrasound appointment**, if I do not cancel at least **48 hours** prior to my scheduled appointment.
- **$150.00** for a **scheduled surgery**, if I do not cancel at least **72 hours** prior to my scheduled appointment.

______ • I understand this policy, agree to its terms and authorize Galleria Women's Health to assess no show and late cancellation fee according to the policy outlined to the Credit Card /Debit Card that has been provided to Galleria Women's Health or has been listed below:

____Visa ____MasterCard ____Amex ____Discover

Cardholder Name: ______________________________

Account Number: ______________________________

Expiration Date: _______ / ______ CVV: ______________

______ • For Ultrasound/Surgery Appointments, in case of a cash deposit instead of credit card information, I understand that the $75.00/$150.00 deposit will be refunded to me on my first visit after the procedure. For office visit, I understand my cash deposit of $25.00 will remain on my account for as long as I am a patient of Galleria Women's Health.

______________________________	______________________	______________________
Patient's Printed Name	Patient's Signature	Date
______________________________	______________________	______________________
Legal Guardian	Relationship	Date

LABORATORY SERVICES

PATIENT NAME: ____ DATE OF BIRTH: _______________

Please recall that your insurance policy is a contract between you, your employer and your insurance company. Galleria Women's Health is not a party to that contract.

It is your responsibility to be aware of any **restrictions** imposed by your insurance company, or your employer regarding your laboratory services, any preferred laboratories, **in- or out-of network status** of different laboratories, or any other restrictions

PLEASE CIRCLE YOUR PREFERRED LABORATORY FOR SENDING YOUR SAMPLES AND BLOOD WORK FOR TESTING

LABCORP **QUEST** **OTHER:** ___________________

_____ • I understand that it is my responsibility to be aware of any restrictions imposed by my insurance company, or my employer regarding my laboratory services, any preferred laboratories, in- or out-of network status of different laboratories, or any other restrictions.

_____ • I understand that phlebotomist services at the office of Galleria Women's Health is just a courtesy service provided for patient convenience by Galleria Women's Health. Galleria Women's Health does not conduct laboratory testing (other than urinary pregnancy tests) and these services are provided by the third-party laboratories.

_____ • As a courtesy, Galleria Women's Health will try to send my samples and blood work for testing at my / my insurance carrier's preferred laboratory, however, I understand that Galleria Women's Health cannot guarantee that and that I have the option of requesting the test request form from the physician and getting tests done at a laboratory of my choice.

_____ • I understand that Galleria Women's Health has no control or visibility into the third-party laboratory billing policies or procedures.

_____ • I understand that if there is any billing dispute with the third-party laboratory, Galleria Women's Health is not a party to such a dispute.

______________________	______________________	______________________
Patient's Printed Name	Patient's Signature	Date
______________________	______________________	______________________
Legal Guardian	Relationship	Date

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I, ____, understand that as a part of my health care, Galleria Women's Health originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to bow my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Galleria Women's Health is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization 's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Galleria Women's Health to disclose my protected healthcare information to the following person and/or people:

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

I fully understand and accept the terms of this consent.

____ _________________________

Patient or Legal Guardian Signature Date

FREQUENTLY ASKED QUESTIONS
CREDIT CARD ON FILE – NO SHOW / LATE CANCELLATIONS

1. Why does Galleria Women Health require Credit Card on File?

Galleria Women's Health is committed to providing the highest quality care to our patients in a timely manner. However, we only have a fixed number of appointments available on a clinic day and an extensive waiting list. When you do not call to cancel an appointment in a timely manner, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. In order to continue to better utilize available appointments for our patients in need of medical care, we strictly enforce the following No Show / Late Cancellation Policy. Your credit card will be charged a No Show / Late Cancellation Fee if you do not call to reschedule your appointment in a timely manner

2. How much is the No Show / Late Cancellation Fee?

It depends on your type of appointment. It is as follows:
$25.00 for an office appointment, if not cancelled at least 24 hours prior to the appointment.
$75.00 for an ultrasound appointment, if not cancelled at least 48 hours prior to the appointment.
$150.00 for a scheduled surgery, if not cancelled at least 72 hours prior to the scheduled date of surgery.

3. Why is the No Show / Late Cancellation Fee higher for Ultrasound and Scheduled Surgery?

Ultrasounds: For our patient's convenience, we are able to schedule ultrasounds in our office. However, scheduling your ultrasound requires us to book an ultrasound technician to come to our office and be available for the scheduled times. A late cancellation or no show results in direct costs of the ultrasound technician.

Surgeries: In addition to available surgery slots being very limited, scheduling your surgery requires significant coordination between the hospital or surgery center, your insurance company, anesthesiologist and first assist, if applicable. A late cancellation or no show creates significant disruption and prevents another potential patient to be scheduled for that time slot.

4. How is my credit card information stored?

We place a high priority on keeping your personal and financial information secure. Under the Payment Card Industry Data Security Standard (PCI DSS), our payment processor, Cornerstone, is required to comply with very strict standards to safeguard your credit card information. Galleria Women's Health as a merchant of Cornerstone is also required to maintain PCI compliance. Our staff enters your information into our secure e-payments portal. All communications (between SSSC, e-payments, the acquiring bank and the issuing bank) are encrypted end to end with a 1024-bit RSA public/private key pair assuring server authenticity and invulnerability to man-in-the –middle attacks. Our system runs in secure mode using SSL (Secure Sockets Layer) which encrypts all communication data.

5. What if my credit card information changes?

If the credit card we have on file for you changes, please notify us IMMEDIATELY, by calling our office at (702) 983-2010. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days. We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy.

6. What happens if I do not have a credit card?

If you do not have a credit card or debit card, we can accept a $100 deposit at check-in before your appointment for office visits. For surgeries, the deposit will be $150, which will be refunded to you on your first visit after the surgery.

HIPAA NOTICE OF INFORMATION PRACTICES

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

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve
- Understanding what is in you record and how your health information is used helps you to ensure its accuracy, make more informed decisions when authorizing disclosure to others; and better understand who, what , when, where and why others may access your health information.

Understanding your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your Information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations
- We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change , we will notify you the next time you come to our office for treatment.
- If you believe your privacy rights have been violated, **you can file a complaint with the Office of Civil Rights either by calling 800-368-1019 or by writing to U.S. Dept of Health & Human Services 90 70th Street Suite 4-100, San Francisco CA 94103.**

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

We will use your health Information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services .When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgment, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to the public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.