## NEW PATIENT INFORMATION SHEET

Name: _____ Age: _____

Reason for visit: _____

_____

_____

## Gynecological History

| | | | |
|---|---|---|---|
| Age 1st menses: | # days btwn menses: | | Avg # days flow: |
| Amt of flow: ☐ Heavy ☐ Normal | Pain w/ periods? ☐ yes ☐ no | | Bleeding btwn periods? ☐ yes ☐ no |
| Date of last menstrual cycle: | Post-menopause: ☐ yes ☐ no | If yes, yr of onset:_____ | Post-Menopausal bleeding: ☐ yes ☐ no |
| Sexually Active? ☐ yes ☐ no | Men / Women / Both (please circle) | | |
| What are you using for birth control: | | Problems with this method: | |
| Age 1st intercourse: | | Total # partners: | |
| Bleeding after intercourse? ☐ yes ☐ no | | Problems with intercourse? ☐ yes ☐ no | |
| Date of last pap smear: _____ ☐ Normal ☐ Abnormal | | History of Abnormal Pap Smears? ☐ yes ☐ no | |
| If yes, please provide date & treatment received: | | | |
| History of STDs? ☐ yes ☐ no | | If yes, describe: | |
| Other Gynecological problems (describe) | | | |

## Obstetrical History

| | | |
|---|---|---|
| Total # pregnancies | # deliveries: | # living children: |
| # miscarriages: | # ectopics: | # abortions: |

**Birth History**

| DOB | Hospital | Hrs of Labor | Vaginal or C-Section | Sex | Weight | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| | |
|---|---|
| **Medications** (vitamins, supplements, etc): | |
| Allergies to Medications ☐ yes ☐ no | If yes, list medications & reaction: |
| Medical Problems: | |

Established 2013

Previous Surgeries _____ _____

_____ _____

Psychological History _____
(Ex: anxiety, depression)

Personal History
Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widower Occupation_____
Alcohol use: ☐ Yes ☐ No If yes, frequency ☐ Daily ☐ Socially ☐ Rarely ☐ Never
Tobacco use: ☐ Current ☐ Quit ☐ Never If current, # packs per day:_____
Drug use: ☐ Current ☐ Quit ☐ Never ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other
Have you ever been abused (physical or mental) ☐ Yes ☐ No If yes, by whom?_____

## Family Medical History

| | Age | Relation | Comments |
|---|---|---|---|
| Diabetes | | | |
| High Blood pressure | | | |
| Cancer | | | |
| Breast | | | |
| Ovarian | | | |
| Uterine | | | |
| Lung | | | |
| Colon | | | |
| Skin | | | |
| Heart Disease | | | |
| Kidney Disease | | | |
| Seizures | | | |
| Birth Defects | | | |
| Bleeding Problems | | | |
| Osteoporosis | | | |

## Preventive Medicine

Date of the last mammogram:_____ ☐ Normal ☐ Abnormal
History of abnormal mammograms?: ☐ Yes ☐ No
Date of the last DEXA scan:_____ ☐ Normal ☐ Abnormal
Do you take a calcium supplement?
Date of the last colonoscopy_____ ☐ Normal ☐ Abnormal
How much do you exercise: ☐ Never ☐ Once/week ☐ 2-3 time/week ☐ > 3 times/week

Did anyone refer you to our office today? _____
Who is your primary physician? Name_____Phone Number_____

# PATIENT INFORMATION SHEET

| | | | |
|---|---|---|---|
| **Name:** | **Address:** | | |
| **Date of Birth:** | **City/State:** | | **Zip Code:** |
| **Home Phone:** | **Work Phone:** | **Cell Phone #:** | |
| **Email:** | | **Soc Sec #:** | |
| **Employer:** | **Address:** | | |
| **Occupation:** | **City/State:** | | **Zip Code:** |
| **Emergency Contact:** | **Relation to you:** | **Phone #:** | |

Race: ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Caucasian/White
☐ Nat Hawaiian/Pacific Islander ☐ Other Race: _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Where do you prefer we contact you: ☐ Home ☐ Work ☐ Cell
May we leave a message with test results? ☐ yes ☐ no

If desired, to whom may we release information about your health issues?
☐ No one but me ☐ Alternate (see below)
Name:_____ Relation to you:_____

## INSURANCE INFORMATION

| Primary Insurance | Secondary Insurance |
|---|---|
| | |
| Insurance company name | Insurance company name |
| Insurance company Phone number | Insurance company Phone number |
| ID #/Group # | ID #/Group # |
| Subscriber's Name | Subscriber's Name |
| Relationship to you | Relationship to you |
| Subscriber's Date of Birth | Subscriber's Date of Birth |

Though I may be covered by insurance, I understand that the payment for all services, facilities, and supplies are my responsibility. I authorize the release of any medical information necessary to process this claim. I permit a copy, or other facsimile reproduction, to be used in place of the original. I hereby authorize Women's Health Specialists to apply for benefits on my behalf for covered services rendered by Women's Health Specialists or by Women's Health Specialists order. I request that payment from my insurance company to be made to be made directly to Women's Health Specialists (or to the party that accepts assignment). I certify that the information I have reported is correct. This authorization may be revoked by me at any time in writing.

Signature:_____ Date:_____ Witness:_____ Date:_____

Established 2013

WOMEN'S HEALTHSPECIALISTS
DEDICATED TO THE PRACTICE OF OBSTETRICS, GYNECOLOGY AND INFERTILITY

ALLA A. BODNER, M.D.
JOSEPH P. CAPEZIO, M.D.
ANDREW S. DEUTSCH, M.D.
CARLA A. LOLY, M.D.
DORINA S. SCAUNAS, M.D.
JULIE C. SNOW, M.D.
SOUJANYA R. TUMMURU, D.O.
NICOLE L. BRADY, C.N.P.
DEBORAH R. JOHNSON, C.N.M.

# E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescibe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Women's Health Specialists can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Name (printed) _____ Date of Birth____/____/____

Signature of Patient _____ Date ____/____/____

Relationship if other than patient _____ Acct #_____

Consent Denied_____ Date _____/_____/____

# Medical Release Form

Though I may be covered by insurance, I understand that the payment for all services, facilities, and supplies are my responsibility. I authorize the release of any medical information necessary to process this claim. I permit a copy, or other facsimile reproduction, to be used in place of the original. I hereby authorize Women's Health Specialists to apply for benefits on my behalf for covered services rendered by Women's Health Specialists or by Women's Health Specialists' order. I request that payment from your insurance company be made directly to Women's Health Specialists (or to the party that accepts assignment). I certify that the information I have reported is correct. This authorization may be revoked by me at any time in writing.

Where do you prefer to be contacted? (Please circle one)
Home Work Cell
What is the number? _____

May we leave a message with test results? (Please circle one) Yes/ No

Who is your Primary Care Physician? _____

Primary Care Physician's Phone #: _____

I give my permission to release any information regarding my health issues and/or test results to

_____, my _____ - _____
(Name, please print) (Relation to you) (Phone Number)

We now have a Patient Portal where you can access your chart online. Please update your email address so we can send you an invite.

Email Address: _____

Do you prefer your test results be sent to you through the online portal or a phone call? _____

Print Name: _____ Acct # _____

Signature: _____ Date: _____

# WOMEN'S HEALTH SPECIALISTS FINANCIAL POLICY STATEMENT

Your clear understanding of our practice Financial Policies and your patient financial responsibilities is important to our professional relationship. Payment of your bill is considered part of your treatment. Please call our billing department at (847) 692-9234 with any questions that you may have.

- **All patients must fully complete our Patient Registration Forms.**
- **If you do not have insurance, FULL PAYMENT IS EXPECTED AT THE TIME OF EACH VISIt**
- **We accept cash, check, Visa, MasterCard or Discover**

## CANCELLATION OF APPOINTMENTS

All of our patients are important to us. Appointment time is allocated specifically to provide you the utmost quality care. By providing at least 24 hours appointment cancellation notice, you allow us to help another patient in need. **Repeated cancellations and/or no-show/no-calls will result in a charge of $50.00.** Your consideration benefits all. Thank you.

PLEASE INITIAL HERE: _____

## FILING INSURANCE CLAIMS

In order to file your claim, we must have a copy of the front and back of your insurance identification cards with the complete claims filing address as well as owner identification, policy and group numbers. Without this information, you will be billed directly. We file claims for most insurance plans. **Balances that remain unpaid may be sent to our collection agency.** You will be **responsible for any fees and charges incurred as a result of this action (charges may include any service charges; attorney's fees; collection fees; late fees and bad check handling charges). Any out of network insurances are treated as self-pay**. You will be financially responsible for any uncovered charges.

PLEASE INITIAL HERE: _____

## MANAGED CARE PLANS: EP-HMO-PPO-POS

*ALL CO-PAYMENTS ARE DUE AT TIME OF SERVICE. If you do not know your co-payment amount, you may use our phone to call your insurance carrier. In order for your claim to be paid by your carrier, you must provide us with any required referral forms or authorizations prior to your visit. **IT IS YOUR RESPONSIBILITY** to verify that we are "in-network" with your managed care plan. If you are scheduled for a procedure, **you must verify that the hospital or facility is "in-network"** to avoid increased deductible and out-of-pocket cost penalties.

PLEASE INITIAL HERE: _____

## MEDICARE/MEDICARE REPLACEMENT

*IF YOU HAVE A MEDICARE REPLACEMENT PLAN, you must contact our office prior to your appointment to verify that we are participating providers with that plan. We accept Medicare and Railroad Medicare assignment. You are responsible only for the difference between Medicare's approved amount, the amount they pay and the deductible or co-insurance due. You will receive a bill after insurance has paid. Medicare may require that you sign an "Advanced Beneficiary notice" (ABN) for some services; we will advise you when this may require.

_____ _____

Signature of Patient or Responsible Party WHS Staff Initials Date

_____ _____

Print Patient's Name Patient Date of Birth

Established June 2014

WOMEN'S
HEALTHSPECIALISTS
DEDICATED TO THE PRACTICE
OF OBSTETRICS, GYNECOLOGY
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DEBORAH R. JOHNSON, C.N.M.

Dear Patient,

Due to the current economic hardship in the state of Illinois, we cannot afford to continue accepting new or established patients covered under the State of Illinois Department of Public Aid (IDPA), also known as Medicaid. Payment from this program is well below our costs of delivering medical care.

All patients are required to provide our office with proof of insurance in order to submit your claims accordingly. If you do not have proof of insurance, you will be required to pay at the time of service or will be asked to reschedule your appointment.

If you are covered under Medicaid and do not inform our office prior to your visit, we will request that you find another physician to provide your medical care. We will be available to provide you with emergency medical care only for the next 30 days from the date this form is signed.

**This is applicable to Medicaid as primary or secondary insurance for new patients and established patients new to the program. Consequently, if your primary insurance does not cover the entire cost of your visit you will be responsible for the balance.**

You may contact the Cook County Health Dept. at (312) 864-6420 to assis you in findind a Cook County primary care clinic nearest you, or you may call Lake County Health Dept at (847) 360-6500 or call your county health dept.

Sincerely,

Women's Health Specialists
1875 Dempster, Suite 245
Park Ridge, IL 60068
847.692.9234(p) | 847.692.5267 (f)

Patient Name:_____ Acct # (office use only):_____

Patient Signature:_____Date:_____

I,_____ hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notive of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available.

---

Patient Signature Date

If you are not the patient, please specify your relationship to the patient:

---

I hereby authorize release of medical records necessary on my behalf to the filing of insurance claims through my designated insurance provider.

It is also understood that medical records are confidential, and that release of some for any reason other than payment of medical bills through insurance, must be pre-approved per written request by myself, on and individual basis, and dated accordingly.

---

Patient Signature Date

I hereby authorize payment of surgical and/or medical benefits, for services related to my clinical care, to be sent directly to the providing physician. I recognize responsibility for the fees charged is my own. Therefore, reimbursement is due directly to me is all fees have been paid prior to submission of insurance claim.

---

Patient Signature (Parent if a Minor) Date

# HIPAA Notice of Privacy Practices

*Effective Date:* September 23, 2013

**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 this notice, please contact Office Manager.

## OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

*For Treatment.* We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

*For Payment.* We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

*For Health Care Operations.* We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

*Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.* We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

*Individuals Involved in Your Care or Payment for Your Care.* When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

*Research.* Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

## SPECIAL SITUATIONS:

*As Required by Law*. We will disclose Health Information when required to do so by international, federal, state or local law.

*To Avert a Serious Threat to Health or Safety*. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

*Business Associates*. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

*Organ and Tissue Donation*. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

*Military and Veterans*. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

*Workers' Compensation*. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

*Public Health Risks*. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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.

*Health Oversight Activities*. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

*Data Breach Notification Purposes.* We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

*Lawsuits and Disputes*. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

*Law Enforcement*. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

*National Security and Intelligence Activities*. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

***Protective Services for the President and Others.*** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

***Inmates or Individuals in Custody.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if 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) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

***Individuals Involved in Your 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.

***Disaster Relief.*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

***Right to Inspect and Copy.*** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Medical Records. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***Right to Get Notice of a Breach.*** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

***Right to Amend***. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Office Manager.

***Right to an Accounting of Disclosures***. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Office Manager .

***Right to Request Restrictions***. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Office Manager. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

***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 by mail or at work. To request confidential communications, you must make your request, in writing, to the Reception desk. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

***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. You may obtain a copy of this notice at our web site, www.whsmd.com. To obtain a paper copy of this notice, call our office or request it at the Reception desk.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you can file a complaint alleging violation of Privacy, Security and Breach Notification Rules. You use the OCR Complaint Portal or the OCR Health Information Privacy Complaint Form Package. You can also request a copy of the form from OCR regional office. If you need help filing the complaint or have a question about the complaint or consent form, please e-mail OCR at OCRComplaint@hhs.gov. To file a complaint with our office, contact the Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.