ADVANCED CARE SPECIALTY for Women

WELCOME! Thank you for choosing us for your care. Our mission is to provide the highest quality care that is convenient and comprehensive to our patients. I effort to reduce confusion between our patients and the practice we have adopted the following policies for our office

Please read in its entirety

For Prescription Refills, please Contact your pharmacy and have them send a refill request.

No Child Under the age of 18 may be left unattended anywhere in our facility.

Please call us and let us know if you are unable to make it to your appointment at least 24 hours in advance. If you "No Show" for your appointment three times, we will discontinue care for you at our facility.

We have ownership interest in the Ultrasound Scan services offered at Advanced Specialty Care for Women. You have the right to receive that service at another facility if you desire to do so. Please advise the staff if you elect another facility.

REMINDER

We are required by law to collect your copays, deductibles, and co-insurance in a timely matter. Please assist us with this by having your payment ready at time of service.

All account balances are due within 30 days of receiving a statement. Any Account with an outstanding balance after 90 days will be transferred to an outside collection agency*. Please note at the time your account is transferred your account will be charged* ***$25.00 transfer fee*** *and they may have additional fees if not promptly paid*. It is very important to keep us informed if you are on a payment arrangement and are going to miss a payment to avoid these additional fees. Also if your account is transferred to an outside collections agency we will no longer be able to see you until your account is paid in full.

Please also be aware, that anytime there is a lab drawn or specimen taken from you (biopsy, blood, swabs, Pap smear, excision, etc...) will be sent to an outside lab. So you will receive a bill from that lab in addition to our charges. Please ask if you have any concerns regarding which lab will be used for you and/or lab charges.

Please do not hesitate to contact us if you have additional questions our hours are Monday – Thursday 8:00 am—5:00 pm. If you reach our answering service you will have the ability to leave a message.

X _____

ADVANCED CARE SPECIALTY for Women

We offer many different services for your convenience, please talk to us if you are interested in receiving any additional services and we will gladly get you scheduled or get you the information you need to make a decision in your healthcare.

1. Surgery- we do in office surgeries and surgeries at the local hospitals.
2. Maternity Care and Delivery
3. Contraception Management
4. Novasure
5. 3 D Ultrasounds (FUN!)
6. Ultrasounds
7. Physician Supervised Weight loss program
8. Hormone Replacement Therapy for Women and Men
9. Option based health care, we want you to be a part of your medical care and decisions!
10. Lab draw services

If you are interested in receiving any of the above services, just talk to us! We would be happy to assist you in your health care needs.

ADVANCED CARE SPECIALTY for Women

Patient Intake Form

FULL LEGAL NAME: _____

Date of Birth: _____ SSN: _____ Gender: _____

Mailing Address: _____ APT No: _____

City: _____ State: _____ ZIP Code: _____ County: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ Partner

Home phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Method of Contact: (Please Circle Phone ☐ Text ☐ Email(Portal) ☐

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Referring Provider: _____

Pharmacy: _____ Location: _____ City/State: _____

RESPONSIBLE PARTY

(Please be aware if you are over 18 years of age you are the responsible party)

Person Responsible: _____ Relationship: _____

Date of Birth: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy ID: _____

Group No: _____ Policy holder: _____

Policy Holder Date of Birth: _____ SSN: _____

Phone: _____ Address of Policy Holder: _____

Is this your only insurance YES / NO City, ST, ZIP: _____

By Signing Here, I agree that I am financially responsible for this account and I give consent for care/treatments to Advanced Specialty Care for Women.

X_____

ADVANCED CARE SPECIALTY for Women

HISTORY

Patient Name: Date of Birth:

Today's Date: Nickname:

Age: Marital Status: □ M □ S □ D □ W □ Partner

Have you had or do you have?	*YES*	*NO*	*Patient History:*	*YES*	*NO*	*Comments:*
Endometriosis			*Breast Cancer*			
Chronic Pelvic Pain			*Colon Cancer*			
Abnormal Pap (history)			*Other Cancer*			
Urinary Tract Infections			*Hypertension*			
Urinary Incontinence			*Elevated Cholesterol*			
Osteoporosis			*Heart Attack*			
LIST CURRENT MEDICATIONS			*Heart Murmur*			
			Stroke			
			Clotting Disorder			
			Anemia			
			Thyroid Problems			
			Diabetes			
If additional please provide list			*Emphysema*			
SURGERIES/PROCEDURES	*YEAR*		*Chronic Bronchitis*			
			Ulcers			
			Colitis			
			Colon Polyps			
			Gallstone			
			Liver Disease			
HABITS	*YES*	*NO*	*Arthritis*			
Smoking?			*Autoimmune Disorder*			
Do you consume alcohol?			*Migraine Headaches*			
Do You use illegal drugs?			*Multiple Sclerosis*			
Do you Exercise Regularly?			*Seizures*			
Safety			*Glaucoma*			
Are you currently being sexually or physically abused?			*Stress/Anxiety*			
Have you been sexually or physically abused in the past?			*Depression*			
Do you wear Seatbelts?			*Chemical Dependency*			
			Alcoholism			

Past Pregnancies- Date – Month/ Year

Date Mo/Yr.	*Vaginal*	*Cesarean*	*Miscarriage*	*Gest. Age Weeks*	*Male*	*Female*	*Weight/Complications*

ADVANCED CARE SPECIALTY for Women

Menstrual History

When was the first day of your last period?		Menopausal Symptoms?		YES ☐	NO ☐
Typical # days of flow		Post- Menopausal Symptoms		YES ☐	NO ☐
Typical Number days from 1st day of period to 1st day of next period?		If post-menopausal, month/ year of last period?			
Amount of Flow?		○ None	○ Mild	○ Mod	○ Severe
Menstrual Cramps		○ None	○ Mild	○ Mod	○ Severe
Symptoms of PMS		○ None	○ Mild	○ Mod	○ Severe
Bleeding between Periods		○ None	○ Mild	○ Mod	○ Severe

Current Method of Contraception? _____

History of STD's? _____

Health Maintenance Screening Tests

	Date	Result		Date	Result
Mammogram			Stool Blood		
Lipid Screen			Colonoscopy		
PAP Smear			Bone Density		

Incontinence Questionnaire

Can you control the urge to urinate?	YES ☐	NO ☐	Do you leak Urine when you cough, sneeze or laugh?		YES ☐	NO ☐
If yes, do you leak before reaching toilet	YES ☐	NO ☐	How many times per day do you leak?	None ☐ Mild ☐	Mod ☐	Severe ☐
Number of times voiding in 24 hours?			Do you wear protection because of leaking?		YES ☐	NO ☐
Number of times voiding at night			Do you strain to pass urine?		YES ☐	NO ☐
Urine Leakage during or after sexual intercourse?	YES ☐	NO ☐	Experienced blood in urine		YES ☐	NO ☐
Experience paid during or after voiding?	YES ☐	NO ☐	History of bedwetting?		YES ☐	NO ☐

Family History

Is there a family history of …	YES	NO	Relationship (Father, Mother, Brother, etc.)	Living	Deceased	Age Deceased
Breast Cancer	○	○		○	○	
Ovarian Cancer	○	○		○	○	
Colon Cancer	○	○		○	○	
Other Cancer	○	○		○	○	
Osteoporosis	○	○		○	○	
Hypertension	○	○		○	○	
High Cholesterol	○	○		○	○	
Heart Disease	○	○		○	○	
Stroke	○	○		○	○	
Blood Clots	○	○		○	○	
Diabetes	○	○		○	○	
Thyroid Disease	○	○		○	○	
Autoimmune Disorders	○	○		○	○	
Alcoholism	○	○		○	○	
Depression	○	○		○	○	
Other Mental Illness	○	○		○	○	

ADVANCED CARE SPECIALTY for Women

REVIEW OF SYSTEMS

Circle ALL THAT APPLY

GENERAL	Negative	Fever Weight Loss Night Sweats Weight Gain
EYES	Negative	Vision Changes Glasses Blurry Vision Vision Loss Contacts
ENT	Negative	Headaches Sinus infections Seasonal Allergies Bloody noses Sore Throat Dental Problems
Endocrine	Negative	Excessive Thirst Excessive Urination Hair Loss Excessive Hunger Heat/Cold Intolerance Hot flushes
Respiratory	Negative	Wheezing Coughing up blood Pain when breathing Short of breath Coughing up foam
Breast	Negative	Blood Discharge Painful breasts Milky discharge Dimpling Nipples Lumps
Cardiovascular	Negative	Short of Breath Chest Pain Waking up short of breath Swelling in Legs Irregular Heart Beat
Gastrointestinal	Negative	Constipation Flatulence Black or Tarry Stools Heartburn Diarrhea
Musculoskeletal	Negative	Muscle or Joint Pain Poor Memory Clumsiness Headaches Non- Restful sleep Dry Mouth/ Eyes
Skin	Negative	Dry Skin Pigmented Spots Ulcers Rash Spots changing size Moles
Neurological	Negative	Headaches Numbness Seizures Sudden Vision loss Tremors Passing out
Psychiatric	Negative	Anxiety Thoughts of suicide Hallucinating Feeling Sad Can't Concentrate Heating Voices

ADVANCED CARE SPECIALTY for Women

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. **CONSENT FOR TREATMENT**. I voluntarily consent to inpatient and/or outpatient care and treatment performed by my physician and all other health care providers at Advanced Specialty Care for Women. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider. I also understand that in the course of my medical treatment I may have one or more photographs of my skin or wound(s) taken, to use in monitoring my treatment and guiding healthcare provider interventions. I understand that individuals who want to learn about the roles of healthcare providers may observe the treatment I receive and I consent to this but I have the right at any time to object to letting such an individual observe and my objection will be honored. If this Patient Registration and Consent for Treatment is signed as part of an Emergency Department or other outpatient visit, it will continue for any related inpatient admission.

2. **AUTHORIZATION, FOR RELEASE OF INFORMATION**. I authorize Advanced Specialty Care for Women and its health care delivery sites to utilize confidential medical/Surgical or other information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes. I further authorize the release and discharge of such confidential, information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of an Acquired Immunodeficiency Syndrome (AIDS) diagnosis or a positive Human Immunodeficiency Virus (HIV) antibody test result, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me.

3. **WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES.** I understand that the Advanced Specialty Care for Women or any of its health care delivery sites do not assume any responsibility for the loss or damage to my personal property.

4. **PAYMENT AGREEMENT AND ASSIGNMENT.** Except as prohibited by any agreement between my insurance company and Advanced Specialty Care for Women, or by state or federal law, I agree to be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I authorize Advanced Specialty Care for Women to file any claims for payment of any portion of the patient bills and assign all rights and benefits to Advanced Specialty Care for Women as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event Advanced Specialty Care for Women take action to collect same because of my failure to pay in full all incurred charges.

I have read this form, and by signing this form I understand and agree to what it says. The consent for treatment shall be effective for (1) year.

X_____ DATE: _____

Patient Signature Date (Or parent/guardian/other authorized person if Patient is a minor, mentally incompetent, or _____ physically unable to sign this form)

X_____

Witness to Signature

Printed name of authorized Signature: _____

Reason person is unable to sign: _____

ADVANCED CARE SPECIALTY for Women

Dear Patient,

Payment is required at time of service.

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balance could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that any have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payments, or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Thank you for your understanding in the matter.

X _____

Responsible Party Signature

HIPAA Notice of Privacy Practices - (45 C.F.R. § 164.520)

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 our privacy officer Jennie Coleman, at Advanced Specialty Care for Women.

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.

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.
13. Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
14. 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.
15. 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.

16. 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.
17. 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.
18. 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.
19. 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.
20. 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.
21. Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
22. 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
23. 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.
24. 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 Advanced Specialty Care for Women, 16111 N. Brinson St, Ste 110, Nampa, ID 83687. 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 Advanced Specialty Care for Women 16111 N Brinson St, Ste 110 Nampa, ID 83687.

ADVANCED CARE SPECIALTY for Women

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 Advanced Specialty Care for Women 16111 N Brinson St, Ste 110 Nampa, ID 83687.

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 Advanced Specialty Care for Women 16111 N Brinson St, Ste 110 Nampa, ID 83687. 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 Advanced Specialty Care for Women 16111 N Brinson St, Ste 110 Nampa, ID 83687. 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. To obtain a paper copy of this notice, you must make your request, in writing, to Advanced Specialty Care for Women 16111 N Brinson St, Ste 110 Nampa, ID 83687. 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 may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager at Advanced Specialty Care for Women 16111 N Brinson St, Ste 110 Nampa, ID 83687

You may designate two people to whom we may discuss your condition and treatment:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

By Signing Here I acknowledge that I have read and understand the Privacy Practices for Advanced Specialty Care for Women. I am also aware that if I listed anyone above they will be able to receive any of the information discussed with this office regarding my health care. I understand that I can revoke this authorization anytime in writing to Advanced Specialty Care for Women.

X_____