Dr. McSwain

Dr. Ingvoldstad

Peachtree Women's Specialists

Dr. Dozier

Dr. Roberts

Dr. Knoer

Today's date ________________________ Referred by ____________________________

Please print and fill out completely. Account #____________________________

Legal **Name** ____ Date of birth ____________________________

Name we should use (Nickname) ______________________________________ S.S # ____________________________

Home address ____ Apt # _______________

City _______________________________ State _____ Zip code ____________ Home phone ______________________

Occupation ____ Cell phone ______________________

Employed by ____ Work phone ______________________

SPOUSE's name _______________________ Marital status S M D W Your email ___________________________

Spouse's occupation ____________________ Employer _________________________ Work phone __________________

Person with whom we may leave results (name / relation) ____

Emergency contact's name, rel, phone (not living with you) ____

Primary care physician ____ PCP's phone __________________

Referring physician ____ Ref phys phone __________________

If **MINOR**, responsible adult / relationship ____

Address _____________________________ City, state, zip __________________________ Phone __________________

Occupation ___________________________________ Employer ____

Primary Insurance Ins Name ______________________ Effective Date ________________ Phone __________________

Policy holder's name ____ Date of birth __________________

ID # ____ Group number ___________________________________

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Secondary Insurance Ins Name ______________________ Effective date ________________ Phone __________________

Policy holder's name ____ Date of birth __________________

ID # ____ Group number ___________________________________

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Authorization for Treatment:

I consent to examination, treatment and procedures, which may be performed during office visits including emergency treatment considered necessary by the physician and / or his designated provider.

Assignment of Insurance Benefits:

I hereby assign payment directly to Peachtree Women's Specialists for services covered by insurance or other health benefit plans.

Authorization for Release of Information:

I authorize Peachtree Women's Specialists to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV / AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to other healthcare providers to whom or from whom I have been referred for healthcare services or who provide consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of same is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN: ____ **Date** ____________________

Peachtree Women's Specialists

Family History of Cancer Questionnaire

Name________________________________ **Date of Birth** _______________ **Date**________________

Please circle Y to those that apply to **YOU and/or YOUR FAMIL Y** (on both **MOTHER** and **FATHER'S** side.)
Please list your relationship to the individual diagnosed and the age at cancer diagnosis.

Consider parents, siblings, grandparents, aunts, uncles, children, nieces, and nephews.

HEREDITARY BREAST and OVARIAN CANCER SYNDROME

		Relationship	Age at Diagnosis
Breast cancer before age 50	Y N	______	______
Ovarian cancer at any age	Y N	______	______
Breast cancer in both breasts or multiple primary breast cancers at any age	Y N	______	______
Male breast cancer at any age	Y N	______	______
3 or more breast cancers on the same side of the family at any age	Y N	______	______
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y N	______	______

LYNCH SYNDROME / HEREDITARY NONPOLYPOSIS COLORECTAL CANCER

		Relationship	Age at Diagnosis
Endometrial (uterine) cancer before age 50	Y N	______	______
Colorectal cancer before age 50	Y N	______	______
Colorectal or endometrial cancer at any age AND another family member on the same side of the family with any cancer listed below at any age:	Y N	______	______

Colorectal, Endometrial, Ovarian, Stomach, Kidney/ Urinary Tract, Brain, or Small Bowel

If you circled yes to one or more statements on the Family History Questionnaire, you may be appropriate for a blood test to help determine if you have an inherited risk of cancer.

FOR OFFICE USE ONLY

O Patient offered genetic testing
O **Accepted** O **Declined**

O Information given to patient for review
O Follow up appointment scheduled for date __________________

Provider's Signature________________________ Date________________

PEACHTREE WOMEN'S SPECIALISTS
PATIENT MEDICATION LOG

Patient Name: ____

Drug Allergies: ____

Date	Medication Name	Dose	Frequency	Doctor/Nurse-MA

Melissa Counihan, M.D.
Bonita Dozier, M.D.
James Ingvoldstad, M.D.
James C. Knoer, M.D.
Helen F. McSwain, M.D.
Archibald Roberts, M.D.
Lillian Schapiro, M.D.

PEACHTREE WOMEN'S SPECIALISTS

Vaccination History Questionnaire

Date: ______________________________

Patient Name: ________________________ DOB: ____________________

- Every hour a woman is diagnosed with cervical cancer in the United States.
- Over 600,000 adults each year are diagnosed with pertussis (whooping cough) in the U.S.
- Over 30% of people with Hepatitis A and over 50% of people with Hepatitis B have not signs or symptoms. There is no medication to treat acute Hepatitis.

Are you current on your vaccinations?

If you are like most of our patients, you don't know. If you can't remember the last time you were vaccinated or which ones you previously received, it's time to get vaccinated! Please ask your health care provider about getting vaccinated today.

If you would like more information about your vaccines, please ask us for a copy of the Vaccine information sheet or go to www.immunize.org.

Vaccinations / Boosters

Have you ever been vaccinated for Hepatitis A? ○ Yes ○ No ○ Unsure

Have you ever been vaccinated for Hepatitis B? ○ Yes ○ No ○ Unsure

Have you had pertussis (whooping cough) booster? ○ Yes ○ No ○ Unsure

Have you had a recent tetanus booster? ○ Yes ○ No ○ Unsure

Have you had a flu shot this year? ○ Yes ○ No ○ Unsure

If under 26, have you had cervical cancer vaccinations? ○ Yes ○ No ○ Unsure

I decline updating my vaccinations. ______________________________

Signature

Atlanta Women's Healthcare Specialists, LLC

275 Collier Road, NW Atlanta, Georgia 30309

FINANCIAL POLICY

Patient Name:____
(Please print)

Atlanta Women's Healthcare Specialists' providers are committed to meeting your health care needs! We are pleased that you have chosen us! Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

Patient Responsibility

1. All co-payments are due at the time of visit. Post dated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our physicians are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. It is your responsibility to notify the office of any change in your mailing address and phone number(s).
8. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
9. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.

Fees

1. The returned check fee is $30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery. No more than 5 pages may be faxed. *We strongly discourage faxing medical records unless the recipient has a dedicated and personal fax for delivery.*
5. When a physician treats you via telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis, and treatment (i.e., calling a prescription or refill into a pharmacy), the provider **may** bill a $50 or $75 service fee. There is no charge for labor related calls, OB problems, and emergent medical issues.

Administrative Services

There is a fee for patient Administrative Services. Our office collects an **OPTIONAL** Administrative Service Fee of $5.00 per office visit for Gynecologic visits and $75.00 per pregnancy for Obstetrical visits (payable at the beginning of the Prenatal Care) which covers **all** forms that need to be completed during your pregnancy. **YOU ARE NOT REQUIRED TO PAY THIS FEE**; however, if you choose not to pay the fee there is a $20.00 charge for **each** required Administrative Service payable prior to service completion.

This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

_______ (Initial) **I accept the Administrative Service Fee. I will pay $5.00 per visit. (GYN)**

_______ (Initial) **I accept the Administrative Service Fee. I will pay $75.00 today. (OB per pregnancy)**

_______ (Initial) **I decline the Administrative Service Fee. By declining the Administrative Service Fee, I understand that I will be charged $20.00 for each Administrative Service requested.**

My signature authorizes Atlanta Women's Healthcare Specialists, LLC, to file insurance claims on my behalf to Medicare or other insurance plans and for payments of any benefits due under my insurance plan to be made to Atlanta Women's Healthcare Specialist, LLC when insurance is filed on my behalf.

By my signature below, I acknowledge that I have read and understand this Financial Policy.

Patient Signature ____ Date ______________________________

PEACHTREE WOMEN'S SPECIALISTS, P.C.

Obstetrics and Gynecology

Helen F. McSwain, MD
James P. Ingvoldstad, MD

Bonita Dozier, MD
Archie L. Roberts
James C. Knoer, MD

275 Collier Road, NW
Suite 250
Atlanta, GA 30309
Phone: 404.355.1285
Fax: 404.351.5840

3020 Paces Miill Road
Suite 225
Atlanta, GA 30339
Phone: 404.355.1285
Fax: 770.437.4228

KNOW YOUR INSURANCE AND

MAXIMIZE THE BENEFITS

To ensure that your insurance does pay if you have a covered expense, please follow The instructions below:

PRIOR TO YOUR VISIT:

1. Look at your insurance card. If you do not know what is covered, call the toll free number usually listed on the back of the card. Someone will be able to answer your benefits questions.
2. If your insurance requires a referral from your primary care physician, you must contact your primary care physician to discuss your need to see a specialist. If he agrees that you should see a specialist, he/she will contact **YOUR** insurance company and obtain a **REFERRAL NUMBER**.
3. Please bring the referral number issued by your insurance company in with you. If a referral number is required by your insurance company, and you do not have it with you at the time of your visit, you may be required to pay for services received that day or you may need to reschedule your appointment. (We know your time is very valuable and that you do not want to come in to our office only to have to reschedule your appointment.)

   Most managed care plans do not issue referral numbers after the service has been rendered, so even if you do pay for the services, you could lose the ability to file the claim!

There are hundreds of different insurance policies and managed care options in Georgia. Our office cannot be responsible for each plan. **Please know your health care and laboratory benefits.**

Please let our staff know if your labs must be sent to a specific laboratory that

Is NOT listed on your insurance card.

Thank you for selecting our office for your healthcare needs.

We look forward to being of service to you now and in the future.

We are honored that you have chosen our team to manage your medical care. Please remember that you are ultimately responsible for the payment of charges for the services rendered for your medical care. If you are a member of a managed care plan, you are responsible for complying with all of the procedures required by that plan to enable is to receive payment on your behalf. To ensure that your insurance r medical plans will provide covered benefits, you must let us know of all pertinent insurance coverage at the time you schedule your appointment and when you check in for your office visit. If you will be paying personally for out services or if you are responsible for a deductible, co-payment and/or co-insurance, we expect payment at the time of service. For your convenience, we accept cash, personal checks, VISA, MasterCard and American Express. If you are experiencing personal circumstances that will make the payment of our charges difficult for you, please contact our office manager at 404-355-1285 ext 5242.

HMO'S, PPO'S AND OTHER MANAGED CARE PLANS:

We participate with many HMO, PPO and POS plans, and other managed care medical plans currently offered in this area. In order for our services to be covered under your plan, we must comply with the plan's requirements. It is your responsibility to know your plan's requirements for coverage. We will gladly assist you with what we know; however, since these are not "our" plans, we cannot make final determinations regarding coverage. This must be done by your plan. All co-payments must be collected at the time of service. In addition, if your services are subject to a deductible and/or co-insurance we may require a deposit. We are always available to assist you in these matters. Please note; we are not participating with any of the Medicaid plans.

MEDICARE AND SUPPLEMENTAL PLANS:

We are participating providers for Medicare; therefore we will file your Medicare and your supplemental insurance claims for those plans that accept a claim directly from Medicare. If your supplemental plan does not accept a claim directly from Medicare, you must pay the co-payment to us, and we will file a claim to your plan after we receive an EOB (Explanation of Benefits) from Medicare. Some tests are considered a medical necessity (i.e. pap smears) by our physicians, but Medicare will not pay for this except under certain circumstances. You will be required to sign a form (Advanced Beneficiary Notice) which states that you will be responsible for paying the bill, should Medicare determine it is not payable (i.e. only covered every two years). Please consult with your physician about these requirements.

Thank you for selecting our office for your healthcare needs.

Revised: September 23, 2013

Atlanta Women's Healthcare Specialists, LLC
Notice of Privacy Practices

As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 the Office Manager/Privacy Officer Peachtree Women's Specialists, PC.

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 are 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 in writing to our practice Office Manager/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 the highest quality. We may also share information with other entities that have a relationship with you (for example, your health plan) for their care operations 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 medical 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 disaster relief efforts.

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 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 may also 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 for work related injuries or illnesses.

Public Health Risks. We may release 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 whom 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 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 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 identity 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 the 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 of 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 to determine 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 custody of a law enforcement official, we may release Health Information to the correctional institution of law enforcement official. This release would be necessary; (1) for the institution to provide healthcare; (2) to protect your health and safety or the health and safety of others; (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 of 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 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 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 request 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 a request in writing to
Office Manager, Peachtree Women's Specialists, PC 275 Collier Road NW Suite 250 Atlanta, GA 30309.
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 a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny a 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 Electronic Copy of Electronic Medical Records. If your protected Health Information is maintained in a electronic format (known as electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given 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 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
Office Manager, Peachtree Women's Specialists, PC 275 Collier Road NW Suite 250 Atlanta, GA 30309.

Right to Accounting 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
Office Manager, Peachtree Women's Specialists, PC 275 Collier Road NW Suite 250 Atlanta, GA 30309.

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 healthcare operations. You may 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
Office Manager, Peachtree Women's Specialists, PC 275 Collier Road NW Suite 250 Atlanta, GA 30309.
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 emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested 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
Office Manager, Peachtree Women's Specialists 275 Collier Road NW Suite 250 Atlanta, GA 30309.
Your request must specify how or where your 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 website, www.pwspc.com. If you do not have access to the internet or our website, you may request a paper copy of this notice, in writing, to
Office Manager Peachtree Women's Specialists, PC 275 Collier Road NW Suite 250 Atlanta, GA 30309.

CHANGES IN 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 and on our website. 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
Office Manager, Peachtree Women's Specialists, PC 275 Collier Road NW Suite 250 Atlanta, GA 30309
All complaints must be made in writing. **You will not be penalized for filing a complaint.**

PEACHTREE WOMEN'S SPECIALISTS, PC

A DIVISION OF ATLANTA WOMEN'S HEALTHCARE SPECIALISTS, LLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________, have received a copy of Peachtree Women's
Patient Name

Specialists, PC's Notice of Privacy Practices.

_________________________ ___________________
Signature of Patient Date