PLEASE READ

It is highly recommended that you read this document and keep it for your records. It is not our responsibility if you fail to read this information as it relates to the policies and procedures of our practice.

2675 North Decatur Road Suite 501 Decatur, GA 30033-PH: 404-296-1424 - FX: 404-501-7393

Welcome to Premier Women's Specialist. We are indeed pleased that you have chosen our practice for your medical care. We believe in providing superior service utilizing today's technology but with yesterday's compassion. This packet contains vital information concerning your visits to our practice. Please read all of the material carefully, as it will help you gain an understanding of our office practices and procedures. Some of the information contained in this packet may apply to our OB *(pregnant patients only).* IMPORTANT: PLEASE READ

Dr. Daus was born in Louisville, Kentucky but completed his undergraduate degree in Chemistry at Emory University in Atlanta, Georgia. After returning to his birth place, he earned his medical degree from the University Of Louisville School Of Medicine in 1984. Dr. Daus continued his education with an internship in Family Medicine at the University of Alabama in Huntsville, Alabama where his passion for OBGYN grew. He finished his training in Atlanta, where he completed his Obstetrics and Gynecology residency at Emory University in 1988. Dr. Daus manages a successful private practice in Metro Atlanta. He believes in providing the finest in women's health care in a caring, and friendly atmosphere. ***His services include assisting with all aspects of gynecology, pregnancy, labor and delivery, as well as with the special challenges experienced by women who are in the obstetrical high-risk***

DR. DAUS ONLY DELIVERS BABIES AND SERVES ALL OF HIS PATIENTS PREGNANT OR NOT; AT DEKALB MEDICAL CENTER LOCATED AT 2701 N DECATUR ROAD, DECATUR, GA

On your first visit you will be asked to complete a new patient packet that contains questions for you to answer and this information needs to be accurate as it is necessary for Dr. Daus and the continuity of your care. In addition you will need to provide your photo ID and your insurance card so that we may enter all of your pertinent information into our system. This information may be a second request, if it has been more than a year since your last visit, although we may have your paper charts, we will still ask for this information due to those charts being stored off location, and we are now on an electronic system. Dr. Kevin Daus is a solo practitioner and our practice is enrolled in Medicare, Medicaid and a number of other managed and commercial insurance plans. However, there may be some plans that we are not able to accept for many reasons. ***It is imperative that you educate yourself about your individual insurance benefits.*** Our office can under any circumstances guarantee coverage for every service you may encounter as a patient in our office. If you are unsure about your coverage benefits, please call the member services number on your card and ask for clarification.

Your **PRIMARY INSURANCE** will determine how services will be processed for coverage. We file claims to your secondary insurance as a courtesy. However, we reserve the right to not file with secondary insurance carriers. You will be responsible for providing timely payment for balances due to claims being denied based on your coordination of benefits. Insurance information provided or submitted to us past the timely filing date, will

PLEASE READ

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Please note the following;

Medicaid: We only accept Medicaid as the primary insurance; we **do not** bill Medicaid, Peachstate or AmeriGroup as a secondary. It is your responsibility to seek coverage recoupment if Medicaid is your secondary insurance provider.

Payment: Required co-payments and deductibles are due at the time of service. Please be prepared to make this payment. We accept the following terms of payment: Cash, personal check, VISA, MasterCard, Discover, & American Express.

Other Fees: There are fees associated with medical records request and document completion such as disability forms.

Services: Although Dr. Daus, makes every effort to answer as many of your questions as he can, please note that his doing so is a viable form of treatment and at his discretion this may result in a charge for services should your be done outside of an already scheduled appointment.

Self-Pay Patients; Payment for medical services is expected in full at the time services are rendered. The practice may extend a courtesy discount off of some charges.

Payment Arrangements: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, this must be done through our business office prior to your visit. Co-pays are exempt from payment arrangements because your insurance plan requires you to pay your co-payment at the time services are rendered.

Returned Checks: Returned checks will be assessed a $35 return check fee per check. Incurring (2) Returned checks will permanently result in a cash, credit card, money order, or cashier's check only service with our office.

Referrals: If your insurance plan requires a referral from your primary care physician (PCP) in order to see us, it is your responsibility to request and obtain this referral from your PCP. You may ask your PCP to fax this referral directly to our office at (678) 331-5353. Please call our office 48 hours in advance of your appointment to confirm that your referral has been received.

PATIENT DEMOGRAPHICAL INFORMATION

Date:_____Email:_____@_____Cell Phone(_____)_____-_____

Home Phone(_____)_____-_____Work Phone:(_____)_____-_____SS#_____-_____-_____

Drivers License No_____State issued_____DOB:_____

Mailing Address:_____Apt/Bld/Unit Number:_____

City_____State_____Zip_____Marital Status: _M_S D W

PHARMACY/PCP

Name of Pharmacy:_____Address:_____City_____

Pharmacy Phone No:(_____)_____-_____Primary Care Doctor:_____

Primary Care Doctor Phone No: (_____)_____-_____Fax No: (_____)_____-_____

SPOUSE & EMERGENCY CONTACT INFO

Spouse Name:_____DOB:_____Phone No:(_____)_____-_____

Emergency Contact Person in the event we cannot reach you.

Name:_____Phone:(_____)_____-_____Email:_____@_____

PRIMARY INSURANCE INFORMATION

Subscriber:_____

Address:_____

City_____State_____Zip_____

DOB: SS# - -

Relationship to Patient:_____

Name of Insurance:_____

Member ID No:_____

Group ID No:_____

SECONDARY INSURANCE INFO

Subscriber:_____

Address: _____

City_____State_____Zip_____

DOB:_____SS#_____-_____-_____

Relationship to Patient:_____

Name of Insurance:_____

Member ID No:_____

Group ID No:_____

AUTHORIZATION TO BILL INSURANCE & COLLECTIONS POLICY FOR NON PAYMENT

I authorize Premier Women's Specialists to bill my insurance if needed I further authorize the release of any medical information necessary to process all claims related to services rendered. I understand that it is the policy to collect any unmet deductibles, copayments, and other applicable fees in advance of services provided. If we contact you for an unpaid balance it is an attempt to collect a debt and any information obtained will be used for that purpose. Any outstanding bills or fees assessed by your insurance will be expected to be collected before continuation of treatment. Failure to pay outstanding balances cold result in your not being able to schedule future appointments up to and including dismissal from the practice. All bills sent to collections will result in addition l collections fees being added to the balance due. A fee of 40% of the balance will be added to all collection accounts. This does not include any applicable legal fees or court costs. By signing this document you are acknowledging that the insurance information you are presenting is accurate and true and that you are aware and accept the terms of our collections policy.

SGINATURE :_____DATE:_____

PATIENT INFORMATION

Date:_____DOB:_____MM_____DD_____Year

Name:_____
Last First Middle Initial

Age:_____Race:_____Sex: M___F___Hispanic___Y__N

Please check one: Married_Single____Divorced____Widowed_____Partner

REASON FOR VISIT:_____

If medically necessary would you consent to a blood transfusion? ___Y__N

MENSTURAL HISTORY

First Day of your last period?_____Was it Normal?_Y____N

How old were you when you started your period?_____

Are your periods regular?___Y_____N How many days of flow?_____

Is flow? ___Mild_Mod___Heavy - No of pads or tampons per cycle?_____

SEXUAL HISTORY *(Check or circle all that apply)*

How many total sexual partners have you had in your lifetime?_____*{Optional)*

Sexual Orientation: Bisexual_____Heterosexual_____Homosexual_____

Gonorrhea Syphilis Herpes Chlamydia AIDS/HIV Trichomoniasis

FEMALE HISTORY

Cramps____Y_____N Pain_____Y_____N Pain Location:_____

Intensity:_Mild_ Mod_SevereType :_Sharp_Dull_Shooting_____Aching

PLEASE *ONLY* CHECK ALL THAT APPLY

__Sexual Concerns___Pain intercourse____Irregular bleeding_____Itching___Rape

__Burning__PMS___Discharge___Pelvic infection___Infertility_Odor

PREGNANCY HISTORY

Total Pregnancies_____

_Miscarriages(MC)_____Abortions_____Live Births_____

1 Year of Birth:_____Weeks:_____Sex:_____Weight_____Vag_CSec_ MC_

2 Year of Birth:_____Weeks:_____Sex:_____Weight_____Vag_CSec_ MC_

3 Year of Birth:_____Weeks:_____Sex:_____Weight_____Vag_CSec___ MC__

4. Year of Birth:_____Weeks:_____Sex:_____Weight_____Vag_CSec_ MC__

5. Year of Birth:_____Weeks:_____Sex:_____Weight_____Vag___CSec___ MC__

6. . Year of Birth:____Weeks:_____Sex:_____Weight_____Vag_CSec_ MC_

ALLERGIES

Environmental:_____

_____

Medications:_____

_____

PAP SMEAR HISTORY

Abnormal Pap?___Y_N

When?_____

Treatment?_____

Last Pap?_____

Check only those that apply

___Uterine Fibroids__Sores

__Hot flashes/night sweats

_ Leak urine_Endometriosis

Life Style

Smoke_Y_Never_Quit

Drink____Y_Never_ Quit

Drugs:_Y_ Never_Quit

Self Breast Exams?____Y____N

Mammograms?___Y___N

Last Mamm:_____

Colonoscopy?_Y____N

Last Colonoscopy?_____

MEDICATION HISTORY

Please list all Medications including over the counter & herbs_____

_____

_____

_____

_____

_____

_____

YOUR HEALTH HISTORY

Please check only those that apply

__Diabetes_High Blood Pressure_Heart Disease or Murmur_Rheumatic Fever_Blood Clots_Cancer

_Lung Disease (including TB) _Asthma_Ep liepsy_GI Problems_Overweight_Kidney or Bladder problem

_Kidney Stones_Anemia_Blood Transfusion_Bleeding Disorder_Sickle Cell Anemia_Psychiatric illness

_Depression_Migraine Headache_Varicose Veins_Complications from anesthesia_Dentures or capped teeth

_Breast lumps_Needle Biopsy_Lumpectomy_Mastectony_Hypothyroid_Hyperthyroid_Fibro ids

_Bowe l Problems_Painful Urination_Pain with periods

Are you presently being followed by a clinician for lumps?_Y_N

Any other medical history not listed above?_____

SURGICAL HISTORY

Date:	Surgery	Reason	Comments_____
Date:	Surgery	Reason	Comments_____
Date:	Surgery	Reason	Comments_____
Date:	Surgery	Reason	Comments_____
Date:_____	Surgery	Reason	Comments_____

HOSPITALIZATION HISTORY

Date:_____Reason for admission:_____

Date:_____ Reason for admission: _____

Date:_____Reason for admission:_____

Date:_____Reason for admission:_____

Date:_____Reason for admission:_____

FAMILY HEALTH HISTORY

Please use the following abbreviation to all that apply: *Mother (MJ Father (FJ Brother (BJ Sister {SJ Mother's Mom{MGMJ Mother's Dad {MGFJ Dad's Mother (PGMJ Dad's Father {PGFJ Aunts (AJ Uncle (UJ Cousins {CJ*

Diabetes_____Hypertension____Heart Disease___Stroke____Breast Cancer_GYN Cancer____Twins

Other Cancer_____Lung Disease (including TB)_Downs Syndrome_Birth Defects_____Endometriosis

Bleeding Disorders_____Epilepsy____Mental Illness_Other :

SIGNATURE STATEMENT

The information contained in this document is true and correct to the best of my knowledge;

Patient Signature Date

PREMIER WOMEN'S SPECIALISTS
KEVIN M DAUS, MD
OBSTETRICS AND GYNECOLOGY

2675 N Decatur Road - Suite 501 - Decatur, GA 30033 - Phone: 404-296-1424 Fax: 678-331-5353
Alternate Fax: 404-501-7393

REQUEST FOR MEDICAL RECORDS RELEASE

NOTE: This form will be kept on file in your records and only used if needed to obtain medical records for treatment purposes related to your care. By having this document on file, this will possibly prevent your having to return to our office to sign a release in the event Dr. Daus needs to obtain your records from another doctor. Completion of this form is optional.

*PLEASE **DO NOT DATE; PLEASE JUST COMPLETE THE PATIENT INFORMATION SECTION AND SIGN.***

Date_____

Provider Name_____

Medical Practice or Hospital Name_____

Street Address_____

City, State, Z IP ——————————————————————————————

Dear Provider:

Please release my medical records related to medical treatments rendered by you or under your supervision from_____ through_____. This information will be used to further assist in my medical care, and should be faxed or mailed to the number/address listed above:

Patient's Name: _____

Patient's DOB:_____

Patients Printed Name:_____

Patient's Signature:_____

Patient's Social Security No:_____

Date:_____

Faxed To:_____@Fax No: (_____

Faxed by:_____@Premier Women's Specialists

Premier Women's Specialists
Dr. Kevin M. Daus
404-296-1424

ALLERGY AND ASTHMA QUESTIONNAIRE

Date: _____ Name: ————————————————

1. Do you suffer from allergies, including seasonal allergies? Yes No_____

2. If yes, what allergies do you suffer from: ————————————————————

3. SYMPTOMS: Do you have any of the following? (Check all that apply)

NASAL	✓	SINUS	✓	EYES	✓
Runny or Stuffy Nose		Headaches		Red	
Sneezing		Sore Throat		Itching	
Itchy Nose		Post Nasal Drainage		Watery	
Nose Bleeds		Hoarseness		Dark Circles	
Mouth Breathing/ Snoring		Throat Clearing		Puffiness	
Sniffling		Itchy Throat			
CHEST	**✓**	**EARS**	**✓**	**SKIN**	**✓**
Wheezing		Full		Rash	
Coughing		Painful		Hives	
Tightness		Ringing		Eczema	
Shortness of Breath		Hearing Loss		Swelling	
Chronic Bronchitis		Itching		Itching	

4. Do you have family members with allergies? Y■ If yes, relationship:_____

5. Have you ever been diagnosed with asthma? Details:_____

6. Have you ever had any of these tests? allergy testing_ pulmonary function_ allergist exam_

7. Allergy shots? Y■ N_Frequency? _____ Date begun: _____ Date ended:_____

8. Adverse reactions to allergy shots? (Describe) ————————————————————

PLEASE GIVE THIS TO THE MEDICAL ASSISTANT WHEN YOUR NAME IS CALLED.

2675 North Decatur Road
Suite 501
Decatur, GA 30033

PREMIER WOMEN'S SPECIAISTS

INFORMED CONSENT AND REQUEST FOR OFFICE VISIT

I, , acknowledge and understand that as a patient of Premier Women's Specialists, I can expect my office visit to include any combination of the following:

1. **Data Collection –** The office staff and provider (physician or nurse practitioner) will gather information regarding your reason for your visit and any other important information.
2. **Physical Examination –** this portion of your visit will usually include monitoring your blood pressure, weight, and height. We may also check your urine for problems, such as infection. Depending on your problem, a problem -specific physical examination will be performed by the provider and may include a pap smear and/or a pelvic exam.
3. **Blood work –** your provider may choose to refer you to another physician based on your problems.
4. **Referrals –** your provider may choose to refer you to another physician based on your problems.
5. **Additional procedures** - any further procedures (for example, biopsy or ultrasound), if needed, will be discussed by your provider and separate consent will be reviewed if necessary:

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND / OR EXPLAINRED TO ME, THAT I FULLY UNDERSTAND IT CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, WHICH HAVE BEEN ANSWERED SATISFACTORILY . ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENS THAT I DO NOT APPROVE OF WERE STRICKEN BEFORE! SIGNED THIS FORM.

I voluntarily consent to allow Premier Women's Specialists including physicians, nurses, and medical personnel, to perform the procedure listed above.

_____ _____
Signature of Person Giving Consent Date / Time

_____ _____
Witness Reason Patient Unable to Sign

PATIENT'S PRINTED NAME: ——————————————————

Premier Women's Specialists
Financial Responsibility Policy

I understand that **I,** or my guardian_____,
will be responsible for paying any fees not paid by my insurance company.

I also understand that I am responsible for understanding the terms of my insurance coverage and benefits (i.e. deductibles, coinsurances and copays). Premier Women's Specialists will assist you in the accurate filing of claims, but we can't change claims to benefit you. The providers of Premier Women's Specialists will perform services and lab work in accordance with YOUR health needs, and it is your responsibility to decline services and lab work that is not covered by your insurer. Once services are rendered, I agree to pay for them.

If I am unable to pay my balance in full, I will pay according to the payment plan arranged by Premier Women's Specialists. I will attend all scheduled meetings with my financial counselor and I understand that failure to follow financial policy will lead to my account being sent to collections and my dismissal from Premier Women's Specialists. Balances are to be paid at the times services are rendered or a plan can be arranged to pay on services prior to them being rendered.

I understand that if I do not adhere to the payment schedule as set forth that I will be subject to collections methods which can incur additional costs of up to 40% over my charges.

Most lab work is performed by an independent laboratory and I understand that I will be billed separately for those services. If I have questions about my labs I will address them to LabCorp, Quest, ProPath, or their respective representatives. I understand that Premier Women's Specialists can't waive fees for services that are rendered by LabCorp, Quest, Propath or their respective representatives.

If I am a Medicaid recipient, I understand that if I should lose my eligibility or if I should change my CMO without notification to the practice or should I change to any payer other than Peachstate Health Plan, then I shall pay for services rendered or be dismissed from the practice.

If I am not approved by 551, Medicaid of GA Better Healthcare, I understand that all charges will be billed to me or my guardian.

I understand that there are fees for copying of medical records for my use and completing information on forms such as Disability and FLMA.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature Date

Premier Women's Specialists Medicaid

Insurance Disclosure and Acknowledgement

Medicaid Insurance Only

Dear Valued Patient Receiving Medicaid Assistance,

If the services you received in. our office require us to bill with Tricare, Medicaid or a Medicaid CMO (Peachstate, Wellcare or Amerigroup) you MUST sign this acknowledgement stating that you have no additional coverage above and beyond Tricare or Medicaid. Pursuant to the laws that authorize Medicaid.

If you have private health insurance, claims MUST be submitted to your private insurance company first and then Medicaid second (Please note that we do NOT file any form of Medicaid as a secondary insurance). If your claim is submitted to Medicaid as the primary and you have a commercialized insurance; **you are committing insurance fraud.**

By signing this document, you, as the undersigned, swear or affirm under penalty of law that you have no other private health insurance coverage other than the one you are presenting for services rendered. If you are not willing to sign this form we will not be able to accept you as a patient.

I,_____do hereby swear or affirm that I have no other private health insurance coverage and that based upon my signature to this document, this office will be submitting the bills for my medical services to Tricare or Medicaid. If I fail to provide any private insurance information, may be reported to the State for further investigation.

_____ _____

Date Signature

_____

Printed Name

Premier women's Specialist Dr. Kevin M. Daus

Acknowledgement of Welcome Packet

This indicates that you were provided a copy of our Welcome Packet that contains some of the policies and procedures of our practice. By signing this you also agree that it is your responsibility to read the document.

_____

Printed Patient Name

_____

Signature

Date:_____

Premier Women's Specialists

No-Show Policy Acknowledgement From

We make a courtesy call to all patients the day before an appointment and leave a message for patients we are unable to reach. However we suggest you add your appointments to your calendar.

As you schedule your next appointment, please ensure that we have your updated phone number.
If you do not show up and do not call to cancel within 24 hours of your appointment, you will be charged a no-show fee of $50.

I have read and understand the above financial notice, and understand my financial responsibility if I do not show and do not call to cancel within 24 hours of my appointment.

_____ Date___/___/___

PRINT NAME

_____

SIGNATURE

Premier Women's Specialists
Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ Date of Birth:_____

I_____hereby acknowledge I have received and or/reviewed a copy of the Notice of Privacy Practices for the office of Kevin M. Daus, MD., detailing how my information may be used and disclosed as permitted under federal and state law.

Signed:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient:_____

Date

Relationship:

Please complete if unable to obtain written: acknowledgement from patient

On_____ I attempted to obtain a written acknowledgement of receipt of Notice of Privacy Practices from the above-named patient but was unable to because:

( ) Patient declined to sign this Written Acknowledgement

( ) Patient did not understand the request to sign the Written Acknowledgement

( ) Other (specify):_____

_____ _____
Name and Title of Employee Date

Premier Women's Specialists

Forms Completion Policy Effective July 3, 2013

To all patients please note that we will be happy to complete your forms within the guidelines of our policy. However, please note completing forms is done as a courtesy as our main objective is practicing medicine. The process requires search and retrieval of information.
Please review and adhere to the following request when requesting forms to be completed.

I. The costs for completing any and all forms requiring medical health information is $40.00 to be paid "in advance" of completion. **The $40.00 fee is required for each set.**

2. Please allow at least 5 business days before forms can be completed.

3. We will no longer mail or fax forms. We will provide completed forms to you (the patient) via email or you may pick them up. Please check your span, as we will only email them once.

4. Should the form require them to be faxed, an additional cost will be added. Fax cost is $1.00 per page. It is your responsibility to call the company to ensure that they have them. Once we receive a successful send on our end, we will not tie up our work day going back and forth, that is your responsibility. We will notify you once, via text or email that your forms have been sent.

5. **There are NO exceptions to this policy.**

_____
Printed Patient's Name

_____
Patient's Signature

_____
Date

Premier Women's Specialist

Policies & Procedures for Refunds

On some occasion, patients are due to receive refunds from our office. In the case you are due a refund; please note that refund checks are processed monthly on the 15th of every month.

Please sign that you have received a copy of our office policy regarding the way refunds process.

Patient Printed Name: _____

Patient Signature: _____

Today's Date: _____

PWS COLLECTIONS POLICY FOR NON PAYMENT

Our Policy is to collect any unmet deductibles, copayments, and other fees in advance of any services provided by Premier Women's Specialists. If we contact you for an unpaid balance it is an attempt to collect a debt and any information obtained will be used for that purpose.

Any outstanding bills or fees assessed to you by your insurance company will be expected to be paid in full before continuation of services. Should you have financial issues please bring them to the attention of the Practice Administrator in effort to attempt a viable solution. Unfortunately we are a small practice and depend highly upon our patients making timely payments on services rendered.

Your first bill comes from your insurance company in the form of an EOB (explanation of benefits). This document shares with you the amount that was paid by the insurance company and the amount you owe the doctor. There is no need to wait on the office to mail you a bill as your EOB serves as your official notice of what you owe the physician. We will may attempt to reach you by mail, email, or phone in our attempt to collect p a y m e n t .

Our policy is once all of our three methods of contact has been exhausted and payment has not been received after 30 days from the time your insurance pays is to send you to an outside collections agency. Failure to pay your outstanding balance could result in your not being able to be scheduled for future appointments up to and including termination from the practice.

All bills sent to collections will result in additional collections fees being added to your account. A fee of 40% of the balance will be added to all accounts sent to collections for non-payment. You may also be responsible for and legal or court fees that are associated with collecting the debt.

_____

Printed Patient's Name

_____ _____

Patient Signature Today’s Date

_____

Premier Women’s Specialists Representative

NOTICE OF PRIVACY POLICY **Effective August 11, 2015 Please print and keep this information for our records**

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

The following is the privacy policy ("Privacy Policy") of **Premier Women's Specialists / Dr. Kevin M. Daus** ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any, information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Fu1ther, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that pem1ission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent we may use or disclose your personal health informc:1tio in order to provide you with; services and the treatment you require or request, or to collect payment for those services and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include*:* (a) the provision, coordination, or management of health care and rela1ed services by health care providers; (b) consultation between health care provider s relating to a patient; or (c) the referral of a patient for health care from one health care provider to another . ***Examples of payment activities include****:* (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care review,, Utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement. ***Examples of health care operations include:*** (a) Development of clinical guidelines: (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination: (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating: (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is reql1ired by law and the use or disclose complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including preventing or controlling disease or other injury , public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect , or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs: (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoenc1, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death: (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue(g) for research purposes under certain conditions; (h) to avert a serious threat lo health or safely; (i) military and veterans activities: U) national security and intelligence activities, protective services of the President and others: (k) medical suitability determinations by entities that are components of the Department of State; (I) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke e your authorization to use or disclose any personal health information at any time, except to the extent that we have to take action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group, health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions 0n Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of y our personal health information about yourself. You may request restrictions on the following uses or disclosures: to carry out treatment, payment, or healthcare operations, (b} disclosures to family members. relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; {c) instances in which you are not present or your permission cannot practicably be obtained, due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure lo a public or private entity authorized by law or by its charter to assist in disaster relief efforts. While we are not required to agree to any requested restriction. If we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, exception in certain: emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Access and Correction

With limited exceptions, we will give you access to the information we retain about you within a reasonable time, upon presentation of a written request and satisfactory identification. If you find errors of fact in your personal health information, please notify us as soon as possible and we will make the appropriate corrections. We are not required to correct information relating to clinical observations or opinions made in good faith. You have a right to append a short statement of disagreement to your record if we refuse to make a requested change. If we deny your request for access to your personal information, we will advise you in writing of the reason for the refusal and you may then challenge our decision.

Challenging Compliance

We may charge you a fee for this service and if so, we will give you notice in advance of processing your request.

We encourage you to contact us with any questions or concerns you might have about your privacy or our Privacy Policy. We will investigate and respond to your concerns about any aspect of our handling of your information. In most cases, an issue is resolved simply by telling us about it and discussing it. You can reach us at: **Jacqueline Boatwright, Privacy Officer** *Premier Women's Specialists, 2675 N Decatur Suite 501 Decatur, GA 30033 -404-296-1424 - 404-748-4270 (fax)*

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer. All requests for amendment shall be sent to Dr. Kevin M. Daus 26 75 North Decatur Road Site 501 Decatur, GA 30033 A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy' Policy. A complaint must be received by us or filed with the Secretary of DHHS within 18O days of when you knew or should have known that the act or omission complained of occurred. You will not be, retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

If, after contacting us, you feel that your concerns have not been addressed to your satisfaction, you have the right to complain. You can send complaints to: Timothy Noonan, Regional Manager, Office for Civil Rights

U.S. Department of Health and Human Services, Sam Nunn Atlanta Federal Center, Suite 16T70

61 Forsyth Street, S.W. Atlanta, GA 30303-8909: Voice Phone (800) 368-1019 FAX (404) 562-7881

TDD (800) 537-7697