ARLINGTON WOMEN'S CENTER, PLLC

(For office use only)

PRIMARY INSURANCE: ____

SECONDARY INSURANCE: ____

QUEST (we bill) ______
QUEST (lab bills) ______
LABCORP (lab bills) ______

PATIENT INFORMATION

LAST NAME: ______________________________ FIRST:______________________________ M.I.____________

HOW WOULD YOU LIKE TO BE ADDRESSED? (NICKNAME): ________________________

DO YOU IDENTIFY AS: FEMALE MALE NONBINARY OTHER ________________ PREFERRED PRONOUNS: _______________

SOCIAL SECURITY #:________________________ DATE OF BIRTH: _____/_____/__________ AGE: ____________

MARITAL STATUS: ○ SINGLE ○ MARRIED ○ SEPARATED ○ DIVORCED ○ WIDOWED ○ OTHER

HOME ADDRESS: ____

CITY: __________________________________ STATE: __________ ZIP CODE: ______________

NAME OF EMPLOYER: ___________________________________ OCCUPATION: __________________

HOME PHONE:__________________ WORK PHONE:__________________ CELL PHONE:____________________

HIPAA INFORMATION

I prefer that you Call me at: ○ Home ○ Work ○ Cell

I authorize this practice to leave messages regarding my medical appointments, conditions, test results, with:

HOUSEHOLD FAMILY MEMBERS	YES	NO	CELL PHONE	YES	NO
ANSWERING MACHINE HOME	YES	NO	ANSWERING MACHINE WORK	YES	NO

INSURANCE POLICY HOLDER (If you are not the policy holder)

LAST NAME: ___________________________ FIRST:________________________________ M.I.____________

SOCIAL SECURITY #:______________________ DATE OF BIRTH: _____/_____/_________ RELATIONSHIP: ____SPOUSE ____PARENT ____OTHER

SPOUSE INFORMATION

LAST NAME: ___________________________ FIRST:________________________________ M.I.____________

SOCIAL SECURITY #:______________________ DATE OF BIRTH: _____/_____/_________

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY:________________________________PHONE:______________________RELATIONSHIP______________

ETHNICITY

_____HISPANIC OR LATINO _____NOT HISPANIC OR LATINO

PLEASE SELECT ONE OR MORE RACIAL CATEGORY WITH WHICH YOU MOST CLOSELY IDENTIFY:

_____AMERICAN INDIAN OR ALASKA NATIVE _____NATIVE HAWAIIAN OR PACIFIC ISLANDER

_____ASIAN _____WHITE OR CAUCASIAN

_____BLACK OR AFRICAN AMERICAN _____OTHER

_____I DECLINE TO PROVIDE THIS INFORMATION

LANGUAGE PREFERENCE

WHAT IS YOUR LANGUAGE PREFERENCE?

_____ENGLISH

_____SPANISH

_____OTHER PLEASE SPECIFY______________________________

Patient Medical Record Number: ____________________________

PATIENT HISTORY QUESTIONNAIRE

Name: ____**Birthdate:**_____/_____/_______Today's Date: ____/_____/_______

Name of Primary Care Physician: ____________________________Who referred you?_____________________________________

Reason for visit: ___________________________________**DRUG ALLERGIES:** ___________________________________

Have you or anyone in your family (Mom, Dad, siblings, grandparents, aunts, uncles) had the following:
(Use MGM for maternal grandmother, PGF for paternal grandfather, etc. Please include age at diagnosis, if known)

	SELF	OTHER FAMILY MEMBERS
Bleeding Disorders		
Clot in lung or blood vessel		
Diabetes		
Heart Disease		
High Blood Pressure		
Osteoporosis		
Stroke		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
Other Cancer (specify)		

What surgeries have you had?

____

____

____

____

____

____

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____

Please Circle below any of the following YOU have had:

Anxiety	Asthma	Anemia / Blood Transfusion	Hepatitis (A / B / C)	PCOS
Depression	Lung Disease	Thyroid Disease (Hypo / Hyper)	Chlamydia / Gonorrhea	Infertility
Bipolar Disorder	High Cholesterol	Lupus / Autoimmune disorder	Herpes	Breast problems
Substance Abuse	Gallbladder Disease	Migraines	Genital Warts	Uterine abnormality
Eating Disorder	Kidney Disease	Epilepsy/Seizures	Syphilis	Endometriosis
Alzheimer's	Tuberculosis	Problems with Anesthesia	HIV/AIDS	Preeclampsia
				Gestational Diabetes
				DES Exposure

Other Medical Conditions: ____________________________

Do any of the following apply to your family? If so, check box and provide details above:

[ ] breast cancer under age 50
[ ] 2 separate breast cancers in one person
[ ] 3 breast cancers on same side of the family
[ ] male breast cancer
[ ] 3 or more of these on the same side: Colon / Uterine / Ovarian / Gastric
[ ] Ashkenazi Jewish ancestry and any of these: Breast / Ovarian / Pancreatic

Have you had any kind of genetic testing or carrier screening? Y N If yes, when and what kind? ______________________

When was the first day of your last menstrual period? __________ How old were you when you had your first period? __________
How long are your cycles (from the first day of one to the first day of the next)? _______ How long does the flow last? __________
Are your menstrual cycles regular? Y N Are they heavy? Y N Severe cramping? Y N

When was your last Pap smear?_________ Mammogram?_________ Colonoscopy? _________ DEXA (Bone Density Scan)? ___________

Have you ever had an abnormal Pap smear or HPV? Y N When?_____________ How was it treated?_____________________
Have you had 3 doses of the HPV Vaccine (Gardasil)? Y N

Have you ever had sex? Y N How many partners have you had in the last 12 months? ___ Are they: Male Female Trans/Other____

What method of contraception do you use? ______________________ (Examples: condom, pill, IUD, vasectomy, "pulling out")
Are you trying to conceive? Y N Are you interested in conceiving within the next year? Y N

Are you bothered by leaking urine or stool? Y N Would you like to discuss this with your doctor/midwife? Y N

Do you smoke cigarettes? Y N How many per day? ____
How many servings do you consume each week of: Beer_______ Wine______ Hard Liquor_______
How many times in the past year have you had 4 or more drinks in one day? _________

In the past 2 weeks, how often have you been bothered by the following symptoms?

- Little interest or pleasure in doing things: Never Several days More than half the days Nearly every day
- Feeling down, depressed, or hopeless: Never Several days More than half the days Nearly every day

In the past year, have you been threatened, hit, slapped, kicked, or choked by anyone you know? Y N
Has anyone forced you to perform any sexual act that you did not want to do? Y N

Please list the name, dosage and dosing schedule of any medication you currently take, including vitamins/supplements:

____ ____

____ ____

Please list your pharmacy name and phone number: ____

Patient's Signature: ________________________________ **Staff Signature:** _________________________________

PATIENT HISTORY QUESTIONNAIRE continued

Name: ____Birthdate:_____/_____/_______ Today's Date: ____/_____/_______

Pregnancy History:

Date	Location	Vaginal or C-section	Weeks at Delivery	Male/ Female	Weight	Complications during pregnancy, delivery, or postpartum

(Complications may include high blood pressure, diabetes, vacuum or forceps delivery, hemorrhage, postpartum depression, etc)

Any miscarriages, ectopic pregnancies, or abortions not listed above? ____________________________

If this visit is for a new pregnancy, please complete this box.

Current Pregnancy:

Were you on birth control within 3 months of conceiving? Y N If yes, what kind? ____________

Was this pregnancy a result of infertility treatment? Y N If yes, what kind? ________________

If you could change the timing of this pregnancy, would you want it: Earlier / Later / Not at all / This is perfect

Since last period any: Vaginal bleeding Nausea/vomiting Fever Exposure to any illness Radiation exposure Exposure to chemicals (eg pesticides, lead, hazardous materials)

Since last period have you smoked, chewed, used any type of tobacco, or vaped? Y N

Since last period have you used any drugs (eg marijuana, cocaine, opioids)? Y N

Have you or your partner recently traveled outside the United States? Y N If yes when and where? __________________

Do you have objections to any form of medical treatment (for example, blood transfusions)? Y N If yes, describe: __________

What is your ethnicity? ______________ What is the ethnicity of the baby's father? _______________

Please circle if you, or the baby's father, is from one of these backgrounds:

Eastern European Jewish (Ashkenazi)
African American
Mediterranean
Southeast Asian
French Canadian
Cajun

Do you or the baby's father have a birth defect? Have you or has the baby's father had a child born with a birth defect? Y N

If yes, please describe: ____

In your family or the baby's father's family, are there any children with special needs? For example, cognitive impairment/intellectual disability, birth defects, early infant death, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis? Y N

If yes, please describe: ____

Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)? Y N

Patient's Signature: ____ Date: _________________________

Provider's Signature: ____ Date: _________________________

ARLINGTON WOMEN'S CENTER, PLLC

1625 N. George Mason Drive Suite 325 Arlington, VA 22205 703-717-4600

FINANCIAL AND APPOINTMENT POLICIES

Add-On Testing - ARLINGTON WOMEN'S CENTER, PLLC, may have additional testing performed on any abnormal test results (i.e., if your pap smear is abnormal, the lab must perform additional testing on the specimen). Any additional testing will be billed directly to your insurance company or to you directly if you do not have insurance.

Replacement Prescriptions - ARLINGTON WOMEN'S CENTER, PLLC will provide all prescriptions, mammogram orders, sonogram orders, and DEXA scan orders during your appointment at no charge. Should your prescription or order become lost; if you have moved to a new pharmacy and a replacement is necessary; a refill is needed and you are overdue for your annual exam; a $25 fee will be charged that must be paid before the replacement is provided.

Appointment Cancellation, No-show and Rescheduling Policy - Any appointments for Initial Obstetrical patients and office procedures and sonograms that are not cancelled 24 hours in advance will result in a $75.00 charge billed to your account for each appointment. Any appointments for follow up GYN visits or obstetrical rechecks that are not cancelled 24 hours in advance will result in a $50.00 charge billed to your account. Any cancellation or rescheduling of a scheduled surgical procedure without a valid medical reason will incur a $150.00 cancellation fee. Cancellation fees are not covered by insurance.

Rebilling Fees - Your insurance carrier will notify both you and our office with an Explanation of Benefits (EOB) if there is a balance due that is your responsibility. At that time a statement will be sent to you. If the balance is not settled in full within 30 days, or arrangements to settle the balance have not been set up with our financial department, a $10.00 rebilling fee will be incurred. Additional $10.00 rebilling fees will be incurred for each 30-day period that the balance remains unpaid.

Returned Checks - a $35 returned check fee will be charged for any check which is returned regardless of reason.

Form Completion - A $35 administration fee per form is due at the time of request. Please allow 5-7 business days for forms completion. Any forms that are requested to be completed with less than 5 days' notice will be completed for an additional $15 fee.

Medicare - ARLINGTON WOMEN'S CENTER, PLLC **has never participated with Medicare**. Medicare will not pay for annual exams. Medicare will pay for a screening pelvic exam, clinical breast exam and obtaining of a pap smear once every two years. We will file your claims to Medicare; however, the **patient is responsible for payment in full at the time of service for all office services**.

I authorize payment of medical benefits to ARLINGTON WOMEN'S CENTER, PLLC for services provided.

I agree to pay in full any balance for services that are deemed to be my responsibility. This may include services denied by my insurance as non-covered, applied to my deductible, part of my coinsurance, etc. If I fail to pay, I understand that my account may be sent to a collection agency and I may be discharged from the practice. I agree to be financially responsible for any collection fees incurred up to a maximum of 50% of the principal balance.

I understand that it is my responsibility to provide the office of ARLINGTON WOMEN'S CENTER, PLLC, with my current insurance card at the time services are rendered to me. I understand that if I provide incorrect or expired insurance information, I will assume full financial responsibility for all charges incurred.

APPOINTMENT POLICY

Giving you the best care possible is very important to us. We understand that sometimes traffic, parking, and other delays are unpredictable. There are also often unavoidable circumstances that impact our providers' goal to start your appointment at the scheduled time. However, late arrivals hinder our ability to provide you with the most thorough care and decrease the amount of time that we have to spend with other patients. If you know that you may be late, please call the office to provide an idea of your estimated arrival time. We will do our best to accommodate you, possibly by offering an available appointment later in the same day or with another provider. However, if you check in more than 15 minutes after your scheduled appointment, you may be asked to reschedule. Thank you for your cooperation and for being a partner in your medical care.

My signature below indicates my receipt of this notice and my understanding of the policy.

I have reviewed and consent to ARLINGTON WOMEN'S CENTER, PLLC's Financial and Appointment Policies.

______________________________	______________________________	____________________
Signature of Patient or Legal Guardian	Patient's Printed Name	Date

***** SIGN THE LAST PAGE AFTER READING THIS DOCUMENT *****

NOTICE OF PRIVACY PRACTICES

ARLINGTON WOMEN'S CENTER PLLC

1625 N. George Mason Drive Suite 325 Arlington, VA 22205 703-717-4600

Effective Date: September 23, 2013

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
(800) 368-1019
OCRMail@hhs.gov
The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.
You will not be penalized in any way for filing a complaint.

ARLINGTON WOMEN'S CENTER, PLLC
Privacy Officer: Hilda Moreno 703-717-4600

***** BRING THIS SIGNED PAGE WITH YOU TO YOUR APPOINTMENT**
YOU DO NOT NEED TO BRING THE NPP NOTICE ***

ARLINGTON WOMEN'S CENTER PLLC

1625 N. George Mason Drive   Suite 325   Arlington, VA 22205   703-717-4600

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided **Arlington Women's Center PLLC's Notice of Privacy Practices**:

____   ______________
Signature of Patient or Personal Representative   Date

____   ______________
Printed Name of Patient or Personal Representative   Date

***** BRING THIS SIGNED PAGE WITH YOU TO YOUR APPOINTMENT**
YOU DO NOT NEED TO BRING THE NPP NOTICE ***