WOMEN'S HEALTH SPECIALISTS INTAKE HISTORY

NAME: _____ BIRTH DATE: _____/_____/_____ AGE: _____ DATE: _____/_____/_____

NICKNAME OR NAME YOU PREFER: _____ PREFERED PHARMACY: _____

FAMILY PHYSICIAN: _____ REFERRING PHYSICIAN OR NURSE PRACTITIONER: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ PARTNER ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EDUCATION: LAST GRADE COMPLETED _____ ☐ HIGH SCHOOL/GED ☐ 2/4 YEAR COLLEGE ☐ GRADUATE DEGREE
☐ OTHER: _____

OCCUPATION OR LAST JOB IF RETIRED: _____

REASON FOR VISIT: _____

PLEASE COMPLETE THE HEALTH HISTORY BELOW TO HELP US BETTER UNDERSTAND YOUR HEALTH STATUS

DO YOU EXERCISE REGULARLY? HOW OFTEN? _____ WHAT TYPE OF EXERCISE? _____	☐ YES	☐ NO
HAVE YOU EVER SMOKED? # OF YEARS SMOKING? _____ IF YOU HAVE QUIT, WHEN? _____ # OF PACKS OF CIGARETTES PER DAY? _____	☐ NO	☐ YES
DO YOU DRINK ALCOHOL? # PER DAY? _____ # PER WEEK? _____	☐ NO	☐ YES
DO YOU USE STREET DRUGS? (MARIJUANA, COCAINE, METH, ETC.)	☐ NO	☐ YES

DATE OF LAST TEST

	DATE		DATE		DATE
PAP SMEAR		MAMMOGRAM		STOOL TEST FOR BLOOD	
EKG		CHEST X-RAY		COLONOSCOPY	

LIST ALL PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

NAME OF DRUG	STRENGTH	HOW OFTEN	NAME OF DRUG	STRENGTH	HOW OFTEN

LIST ALL DRUG & FOOD ALLERGIES AND REACTIONS THAT OCCURRED

NAME OF DRUG/FOOD	REACTION	NAME OF DRUG/FOOD	REACTION
☐ NO KNOWN ALLERGIES			

LIST ALL HOSPITALIZATIONS & OPERATIONS (MEDICAL, SURGICAL, BIOPSIES, FRACTURES, GYN, PSYCHIATRIC)

DATE	OPERATIONS/HOSPITALIZATIONS	REASON

PLEASE INDICATE IF YOU OR A RELATIVE HAS BEEN AFFECTED BY THE FOLLOWING CONDITIONS BY PLACING THE ABREVATION IN THE BOX. (X)=YOU (M)=MOTHER (F)=FATHER (S)=SISTER (B)=BROTHER (MGP)=MATERNAL GRANDPARENT (PGP)=PATERNAL GRANDPARENT (MA)=MATERNAL AUNT (PA)=PATERNAL AUNT

CONDITION	YOU	RELATIVES	CONDITION	YOU	RELATIVES
ASTHMA OR RESPIRATORY PROBLEMS			HEART DISEASE OR HEART ATTACK		
ANEMIA OR BLEEDING DISORDERS			MITRAL VALVE PROLAPSE		
BLOOD CLOTS OR PHLEBITIS			HEPATITIS OR LIVER DISEASE		
BREAST CANCER			HIGH BLOOD PRESSURE		
OVARIAN CANCER			HIGH CHOLESTEROL		
UTERINE CANCER			STROKE		
CERVICAL CANCER			SEIZURES		
COLON CANCER			THYROID DISEASE		
COLITIS OR STOMACH ULCERS			ANXIETY		
DIABETES			DEPRESSION		
BLADDER OR URINARY INFECTIONS			DRUG ADDICTION		
OTHER KIDNEY OR BLADDER PROBLEMS			OTHER_____		
PROBLEMS WITH PREGNANCY					

REVIEW OF SYSTEMS HISTORY- PLEASE (X) IF ANY OF THE FOLLOWING APPLY TO YOU

EYES	☐ BLURRING OF VISION ☐ LOSS OF VISION ☐ VISION CHANGES ☐ DRYNESS OF EYES
ENT/MOUTH	☐ MOUTH SORES OR ULCERS ☐ DENTAL PROBLEMS ☐SNORING/SLEEP APNEA ☐SEVERE MOUTH DRYNESS
CARDIOVASC.	☐ CHEST PAIN ☐ PALPITATIONS OF HEART ☐ SWELLING IN LEGS
RESPIRATORY	☐ SHORTNESS OF BREATH ☐ WHEEZING ☐ CHRONIC COUGH ☐ BLOODY SPUTUM
GI	☐NAUSEA ☐ VOMITING ☐ DIFFICULTY SWALLOWING ☐ HEMORRHOIDS ☐ DIARRHEA ☐ EXCESSIVE CONSTIPATION ☐ BLACK OR BLOODY STOOLS
SKIN	☐ RASH ☐ CHANGES IN ANY MOLES ☐ LUMPS ☐ DRY OR SENSITIVE SKIN ☐ HIVES
MUSC.SKEL.	☐ JOINT SWELLING ☐ JOINT PAIN ☐ LEG CRAMPS ☐ JOINT STIFFNESS ☐ BACK PAIN
NEUROLOGIC	☐ HEADACHE ☐ TINGLING OR NUMBNESS ☐ SEIZURES ☐ MEMORY LOSS ☐ DIZZINESS ☐ FAINTING
ENDOCRINE	☐ HEAT INTOLERANCE ☐ DISCHARGE FROM NIPPLES ☐ EXCESSIVE THIRST ☐ EXCESSIVE URINATION ☐ WEIGHT LOSS ☐ COLD INTOLERANCE ☐ EXCESSIVE OR ABNORMAL HAIR GROWTH
PSYCHIATRIC	☐ HIGH STRESS ☐ DEPRESSION ☐ SLEEP DISTURBANCES ☐ EATING DISORDER ☐ PMS-PMDD ☐ ANXIETY
HEMATOLOGY	☐ VARICOSE VEINS ☐ EASY BRUISING ☐ CUTS THAT DO NOT STOP BLEEDING
LYMPHATIC	☐ ENLARGED LYMPH NODES ☐ PAINFUL LYMPH NODES

HOW MANY TIMES PREGNANT?		HOW MANY FULL TERM BIRTHS?		
HOW MANY PRETERM BIRTHS?		HOW MANY MISCARRIAGES?		
HOW MANY ABORTIONS?		HOW MANY ECTOPIC OR TUBAL PREGNANCIES?		

MONTH/ YEAR	TYPE OF DELIVERY VAGINAL, C/S, VACUUM	COMPLICATIONS	SEX M/F	CHILD'S NAME

DATE WHEN YOUR LAST PERIOD STARTED?	(MONTH/DAY) _____		☐ N/A
AT WHAT AGE DID YOU START YOUR FIRST PERIOD?			
ARE YOUR PERIODS REGULAR?		☐ YES	☐ NO
HOW MANY DAYS DOES YOUR PERIOD FLOW?			
HOW MANY HEAVY DAYS OF BLEEDING DO YOU HAVE?			
ON YOUR HEAVIEST DAY, # OF PADS/TAMPONS DO YOU USE?			

WHAT TYPE OF BIRTH CONTROL ARE YOU USING? ☐ NOT SEXUALLY ACTIVE ☐ PILL NAME:_____
☐ IUD ☐ CONDOM ☐ DEPO-PROVERA ☐ TUBAL LIGATION ☐ VASECTOMY ☐ HYSTERECTOMY ☐ NATURAL FAMILY PLANNING

DO YOU HAVE ANY PAIN WITH YOUR PERIOD?	☐ NO	☐ YES

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? IF YES, PLEASE DESCRIBE TREATMENT_____	☐ NO	☐ YES
HAVE YOU EVER BEEN TREATED FOR ANY INFECTION BELOW? ☐ VAGINOSIS ☐ GENITAL WARTS ☐ CHLAMYDIA ☐ HERPES ☐ TRICHONOMAS ☐ GONORRHEA ☐ SYPHILIS	☐ NO	☐ YES
DID YOU BECOME SEXUALLY ACTIVE BEFORE YOU WERE 16 YEARS OLD?	☐ NO	☐ YES
HAVE YOU HAD MORE THAN 5 SEXUAL PARTNERS IN YOUR LIFETIME?	☐ NO	☐ YES
HAVE YOU EVER TESTED POSITIVE FOR HIV VIRUS?	☐ NO	☐ YES
DO YOU HAVE ANY PAIN, BLEEDING, OR OTHER PROBLEMS DURING INTERCOURSE?	☐ NO	☐ YES
DO YOU HAVE DIFFICULTY OR INABILITY TO BECOME AROUSED, STIMULATED, OR LUBRICATED?	☐ NO	☐ YES
HAVE YOU NOTICED A LACK OF OR DIMISHED LIBIDO (SEX DRIVE)?	☐ NO	☐ YES
DO YOU HAVE DIFFICULTY OR INABILTY TO REACH CLIMAX OR ORGASM?	☐ NO	☐ YES
DO YOU HAVE ANY PELVIC OR ABDOMINAL PAIN OR TENDERNESS? IF YES, WHERE?_____WHEN?_____ HOW SEVERE? (RATE PAIN ON SCALE 1-10, BEING THE WORST AND 1 BEING THE LEAST) _____ DOES ANYTHING MAKE IT WORSE? _____OR MAKE IT BETTER? _____	☐ NO	☐ YES
HAVE YOU HAD YOUR MENOPAUSE (CHANGE OF LIFE)? IF YES AT WHAT AGE:_____	☐ NO	☐ YES
DO HAVE ANY BREAST TENDERNESS, LUMPS, OR DISCHARGE FROM THE NIPPLES? IF YES, PLEASE EXPLAIN:	☐ NO	☐ YES
DO YOU HAVE ANY UNUSAL VAGINAL DISCHARGE, ITCHING, PAIN, OR ODOR?	☐ NO	☐ YES
HAVE YOU NOTICED ANY UNUSAL LUMPS OR BUMPS IN THE VAGINAL AREA?	☐ NO	☐ YES
DO YOU NOTICE IN BLOOD IN YOUR URINE?	☐ NO	☐ YES
DO YOU HAVE ANY PAIN WITH URINATION?	☐ NO	☐ YES
DO YOU FREQUENTLY HAVE STRONG, SUDDEN URGES TO URINATE?	☐ NO	☐ YES
DO YOU FEEL LIKE YOU ARE ABLE TO EMPTY YOUR BLADDER COMPLETELY?	☐ YES	☐ NO
DO YOU SOMETIMES NOT MAKE IT TO THE BATHROOM IN TIME TO URINATE?	☐ NO	☐ YES
DO YOU OFTEN GO TO THE BATHROOM 8 OR MORE TIMES IN 24 HOURS?	☐ NO	☐ YES
DO YOU FREQUENTLY GET UP 2 OR MORE TIMES DURING THE NIGHT TO GO TO THE BATHROOM?	☐ NO	☐ YES
DO YOU WEAR PADS BECAUSE YOU CANNOT MAKE IT TO THE BATHROOM IN TIME?	☐ NO	☐ YES
DOES THE NEED TO GO TO THE BATHROOM INTERRUPT YOUR DAILY ACTIVITIES?	☐ NO	☐ YES
DO YOU EXPERIENCE A LOSS OF URINE WHEN DOING PHYSICAL ACTIVITIES, SUCH AS LIFTING HEAVY OBJECTS OR EXERCISING?	☐ NO	☐ YES
DO YOU LOSE URINE WHEN YOU COUGH, SNEEZE, OR LAUGH?	☐ NO	☐ YES
DO YOU DO KEGEL'S EXERCISES?	☐ YES	☐ NO

COMPLETED BY: ☐ PATIENT ☐ FAMILY MEMBER ☐ NURSE ☐ PHYSICIAN

SIGNATURE OF PATIENT: _____

WOMEN'S HEALTH SPECIALISTS

DATE:	PHYSICIAN/NP REFERRED BY:	MARITAL STATUS: S M W D SEP
NAME: FIRST MI LAST	DATE OF BIRTH:	SS#:
STREET ADDRESS:	CITY:	
STATE:	ZIP:	EMAIL:
HOME PHONE:	CELL PHONE:	DRIV. LIC.#:
EMPLOYER:	WORK PHONE:	WORK: DAY NIGHT SWING
SPOUSE or PARENT:	DATE OF BIRTH:	SS#:
EMPLOYER:		WORK PHONE:

*********ALL VISITS ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED*********

PRIMARY INSURANCE:		
INSURED'S NAME:	ID#:	GROUP#:
INSURED'S DATE OF BIRTH:	INSURED'S EMPLOYER:	
SECONDARY INSURANCE:		
INSURED'S NAME:	ID#:	GROUP#:
INSURED'S DATE OF BIRTH:	INSURED'S EMPLOYER:	

EMERGENCY CONTACT: Name:_____

RELATIONSHIP:_____ PHONE:_____ WORK PHONE:_____

PLEASE READ AND SIGN: I hereby authorize Women's Health Specialists' physician and assistants to do a history, physical exam, diagnostic procedure, and other tests and treatment as explained to me in the office.

Signature:_____ Date:_____

DIAGNOSTIC TESTING: I understand that if I have a pap smear, biopsy, or other diagnostic tests taken in this office, I will be receiving a separate bill from the lab which performed the processing of that test. The processing is not done in this office.

Signature:_____ Date:_____

AUTHORIZATION TO PAY & RELEASE INFORMATION: I hereby authorize my insurance company to pay directly to Women's Health Specialists the surgical and/or medical benefits, if any, otherwise payable to me for services provided by the staff at Women's Health Specialists. I understand that I am financially responsible for those charges not paid by my insurance. I hereby authorize Women's Health Specialists to release any information acquired in the course of my examination or treatment. I also understand that I will be responsible for any collection expenses, including but not limited to collection agency costs and any legal fees as deemed necessary, if payment is not made in a reasonable timeframe.

Signature:_____ Date:_____

ATTENTION MEDICARE SUBSCRIBERS: I am hereby notified that Medicare will only pay for Well Woman Exams every **two** years. I know I am required to pay in full any Well Woman Exams performed more frequently then this. I further agree to pay any charges not ordinarily paid by Medicare.

Signature:_____ Date:_____

How did you hear about us? ☐ Internet Search ☐ Website ☐ Advertising

☐ Friend/Family Member:_____ ☐ Other:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: I, _____,
PATIENT NAME (PLEASE PRINT)

have received a copy of WOMEN'S HEALTH SPECIALISTS's Notice of Privacy Practices.

Signature: _____ Date:_____
Signature of Patient or Guardian

WOMEN'S HEALTH SPECIALISTS

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

WOMEN'S HEALTH SPECIALISTS
1901 LAFAYETTE RD, STE 100
CRAWFORDSVILLE, INDIANA 47933
(765) 361-8586

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations**. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders**. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options**. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services**. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends**. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required By Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks**. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities**. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement**. We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Organ and Tissue Donation**. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research**. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
8. **Serious Threats to Health or Safety**. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security**. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation**. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION**. Your request must describe in a clear and concise fashion:
   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.
3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION**.
7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.
8. **Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact **WOMEN'S HEALTH SPECIALISTS, 1901 LAFAYETTE RD, STE 100, CRAWFORDSVILLE, IN 47933 OR CALL (765)361-8586 FOR FURTHER INFORMATION.**