GWINNETT OB/GYN ASSOCIATES, P.C.

Today's Date: _____ Chart #: _____

PATIENT INFORMATION (please print – blue or black ink only)

Name: _____ Age:_____ Birth Date: _____
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Social Security Number: _____ Primary Care Physician: _____

Employed? (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer: _____ Work Phone: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip:_____

Marital Status (circle one) Single Married Divorced Widowed **Who referred you here?** _____

SPOUSE INFORMATION

Name: _____ Social Security Number: _____ Birth Date: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

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

INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Group #: _____ ID# _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

Secondary Insurance Co. Name: _____ Group #: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Patient (circle one) Self Spouse Mother Father Other

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if my account must be referred to an agency for collection. Additionally, I understand that if I am covered by an insurance that requires a referral number, <u>it is my responsibility to obtain that referral number prior to my visit.</u>

_____ _____
(Patient's Signature) (Date)

Gwinnett OB/GYN Associates, P.C.
1700 Tree Lane Road • Suite 290 • Snellville, GA 30078 • (770) 972-0330

PRENATAL RECORD

Name: _____ Age: _____ Date of Birth: _____

MENSTRUAL HISTORY: First day of menstrual period: _____ Was it Normal? Yes ☐ No ☐
Type of last birth control: _____ Last used? _____

YOUR PERSONAL PRIOR MEDICAL HISTORY	0 NEG √ POS	REMARKS	HISTORY SINCE YOUR LAST MENSTRUAL PERIOD	0 NEG. √ POS	REMARKS
Heart Disease/Murmurs			Nausea/Vomiting		
High Blood Pressure			Indigestion/Constipation		
Asthma, Tuberculosis			Headache		
Stomach or Bowel Disease/Hepatitis			Bleeding (Specify)		
Bladder/Kidney Disease/Infections, Stones			Vaginal Discharge		
Gonorrhea/Chlamydia/Syphilis			Swelling		
Genital Warts or Herpes			Abdominal Pain		
Gyn. Disorder/Gyn. Surgery			Urinary Problems		
DES Exposure/Abnormal Paps			Viral Infection		
Nervous and Mental Problems			Other Illness/Fever		
Diabetes/Thyroid Problems			X-rays		
Blood Clots in Legs or Lungs			Accidents		
Seizures or Neurological Disorder			Medications/including OTC		
Drug Allergies			Tobacco Use		☐ Pt Counseled
Drug Abuse/History of Use			Drug Use		☐ Pt Counseled
Blood Disease/Transfusions			Alcohol Use		☐ Pt Counseled
Cancer/Other Medical Problems			HIV Exposure		☐ Pt Counseled
Rh, ABO Sensitivity			Cats/Raw Meats (Toxo Risks)		☐ Pt Counseled
Operations, Accidents, Hospitalization			Other		
Anesthetic Complications			Tattoos		
Have you had Chicken Pox?					

PREVIOUS PREGNANCIES: Full Term ____ Premature ____ Abortion/Miscarriage/Ectopic/Mole ____ Now Alive ____ Multiple Births ____

No.	Year	Hospital	Length of Pregnancy	Length of Labor	Type of Delivery	Type of Pain Relief	Weight Of Child	Complications		Comments/ Sex of Child
								Mother	Child	

GENETICS SCREENING: DO YOU, YOUR BABY'S FATHER, OR ANYONE IN EITHER FAMILY	YES	NO		YES	NO
1. PATIENT'S AGE MORE THAN 35 YRS. OLD			11. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
2. NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, OR ANENCEPHALY)			12. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
3. DOWN SYNDROME			13. GREATER THAN 3 MISCARRIAGES OR ANY STILLBIRTHS		
4. TAY-SACHS (EG, JEWISH BACKGROUND)			14. MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD (INCLUDING OTC MEDS)		
5. SICKLE CELL DISEASE OR TRAIT			15. CLEFT LIP, CLEFT PALATE, CLUB FEET		
6. HEMOPHILIA			16. OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)		
7. MUSCULAR DYSTROPHY			17. HEARING LOSS FROM BIRTH		
8. CYSTIC FIBROSIS			18. SUDDEN INFANT DEATH SYNDROME		
9. HUNTINGTON CHOREA			19. BIRTH DEFECTS		
10. MENTAL RETARDATION / FRAGILE X					

COMMENTS/REQUESTS: _____

Gwinnett OB/GYN Associates, P.C.
1700 Tree Lane Rd., Ste 290
Snellville, GA 30078

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 as 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:

The Office Manager or Practice Administrator at (770) 972.0330.

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. **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 maybe using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) 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. **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.

6. **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.

7. **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.

8. **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.

9. **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 communications, you must make a written request to the address above, Attn: Medical Records Custodian. Specify the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need 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 the address above, Attn: Medical Records Custodian. 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 the address above, Attn: Medical Records Custodian. In order to inspect and/or obtain a copy of your IIHI. Our practice will 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 healthcare professional chosen by us will conduct the review.

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 the address above, Attn: Medical Records Custodian. 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 or 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 the address above, Attn: Medical Records Custodian. 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 l2-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 anytime.

7. **Right to Files 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 in writing:

   Gwinnett OB/GYN Associates, P.C., ATTN: Privacy Officer, 1700 Tree Lane Road, Suite 290, Snellville, GA 30078

   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 IHII may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHII 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 the Office Manager or Practice Administrator at (770) 972-0330.

GWINNETT OB/GYN ASSOCIATES, P.C.
Gynecology Questionnaire

NAME:_____ **DATE**:_____

DATE OF BIRTH:_____

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) _____

_____

PAST MEDICAL HISTORY:

List all operations you have had.

	OPERATION	DATE
A.		
B.		
C.		
D.		
E.		
F.		

List all illnesses you have had that required hospitalization.

	ILLNESS	DATE
A.		
B.		
C.		
D.		
E.		
F.		

Have you ever had? (Check yes or no and give dates.)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	
( )	( )	Thyroid Disorder	
( )	( )	Pneumonia	
( )	( )	Tuberculosis	
( )	( )	Heart Murmur	
( )	( )	High Blood Pressure	
( )	( )	Rheumatic Fever	
( )	( )	Diabetes	
( )	( )	German Measles or Vaccine	
( )	( )	Anemia	
( )	( )	Convulsions or Seizures	
( )	( )	Ulcers	
( )	( )	I will accept blood products if necessary	

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	
( )	( )	Kidney Stones	
( )	( )	Kidney Infection	
( )	( )	Bladder Infection	
( )	( )	Genital Herpes	
( )	( )	Gonorrhea	
( )	( )	Syphilis	
( )	( )	Broken Bones	
( )	( )	Arthritis	
( )	( )	Mental Illness	
( )	( )	Serious Injury	
( )	( )	Blood Transfusion	

Please list any additional medical conditions or illnesses:

ILLNESS	DATE

REVIEW OF SYSTEMS:
Are you currently having or have you recently had any of these symptoms? (Check "**YES**" or "**NO**")

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest discomfort on exertion
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C. BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast cancer
( )	( )	Previous mammogram date _____

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E. GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Pain in legs when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

Gwinnett OB/GYN Associates, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy

Practices because:

- An emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

  _____

- Other: _____

  _____

Prepared by: _____
Signature: _____
Date: _____

GWINNETT OB/GYN ASSOCIATES, P.C.

Gynecology Questionnaire (Sheet 2)

NAME: _____

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1._____ 3._____

2._____ 4._____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones) _____

_____

_____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT			
PREVIOUS			

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					
6.					

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death.) _____

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

_____

_____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? ❒ Yes No ❒ How many/day? _____ How many years? _____

Do you drink alcohol? ❒ Yes No ❒ How many drinks/day? _____ Per week? _____

Do you get any regular exercise? ❒ Yes No ❒ How often? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period: _____ Age first started period: _____ Usual number of days from one period to the next: _____

Usual # of days of flow: _____ Are your periods: Light ❒ Moderate ❒ Heavy Any excessive bleeding or spotting between cycles? ❒ Yes No ❒

Cramps with periods? ❒ Yes No ❒ Depression, anxiety, emotional upset before periods? ❒ Yes No ❒

PAP SMEARS:

Last pelvic exam: _____ Last pap smear: _____ Have you ever had an abnormal pap? ❒ Yes No ❒

If yes, what treatment was done? _____ Have your paps been normal since treatment? ❒ Yes No ❒

Did your mother take hormones while pregnant with you? ❒ Yes No ❒

VAGINITIS:

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____

Are you having any problem with discharge now? ❒ Yes No ❒

SEXUAL HISTORY:

Any problems with pain? ❒ Yes No ❒ Any problem with Orgasm? ❒ Yes No ❒ Other? _____

Any history of STDs? HPV ❒ Yes No ❒ Herpes ❒ Yes No ❒ Syphilis ❒ Yes No ❒ Hepatitis ❒ Yes No HIV ❒ Yes No ❒

Gonorrhea ❒ Yes No Chlamydia ❒ Yes No ❒ Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

_____

_____

_____

_____

_____

Gwinnett OB/Gyn Associates, P.C.
1700 Tree Lane Road
Suite 290
Snellville, GA 30078

PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Patient Name _____ Acct# _____

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information **ONLY** with me.

_____ I give my permission to discuss my medical information with the following people:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

YES or **NO** You may leave medical information (test results) on my voice mail at:
(circle one)

Cell # _____

Home # _____

Signed _____Date _____

Gwinnett OB·GYN ASSOCIATES, P.C.

OFFICE POLICY

To Our Patients and Patient Guest:

Gwinnett OB/GYN Associates is pleased to accept patients who have requested our services. We would like our patients to know that we respect their need for a safe, friendly, and caring environment in which to receive care. Our providers and office staff will take the steps, when necessary, to ensure that all visitors to our practice are prevented from experiencing any abusive or offensive behavior while visiting our office. We expect everyone at our practice, this includes: our providers, staff, patients, and any other visitors, to behave in a civil, courteous and respectful manner.

We do reserve the right to discontinue services to patients who are not compatible with our providers or members of our staff. Our office considers the following behaviors to be incompatible with our practice:

- Unwilling to follow medical recommendations or treatment plans.
- Unwilling to schedule recommended follow up visits or tests as prescribed by our providers.
- Repeatedly missing scheduled appointments, without proper notice of cancelation.
- Vulgar or abusive speech toward our providers, staff, or other guest at our office.
- Abuse of our facility, equipment, or supplies.
- Threatening behavior of any kind towards our providers, staff, or other guest at our office.
- Wandering the clinical areas unescorted or otherwise violating patients' privacy rights as outlined under HIPAA.
- Disrespect for the needs of other patients visiting our office.

Our office does require 24 hour notice of cancelation. If we are not notified at least 24 hours prior to your appointment that you are not coming in, a $25.00 fee will be added to your account balance. Also, if you have a scheduled appointment and do not show up for that appointment, you will be charged a $25.00 no-show fee. In situations in which you are hospitalized for delivery or other medical complications, we will be notified of this by Eastside Medical Center and those charges will not be applied.

While the great majority of our patients and guests do not fall into any of these categories, we are required to advise all of our patients of our office policies. Our providers feel that to provide our patients with the best medical care, it takes active participation from both the provider as well as the patient. Once again we would like to thank you for choosing us in your obstetric and gynecologic care.

Sincerely,

The Providers of Gwinnett OB/GYN Associates

I have read and agree with this Office Policy: _____ Date: _____