



WOMEN'S MEDICAL NEW OB FORM

Please complete this form and return it IMMEDIATELY. This helps us get a lot of the paperwork done before you come in for your prenatal consult and cuts down on the time you have to wait. Thank you.

FOR OFFICE USE ONLY

APPOINTMENT

Date _____

Time _____

Day _____

SCHEDULED BY _____

PROOF OF PREGNANCY Yes No

+UPT at WMC Yes No

Name _____ DOB _____ Social Security # _____

Address _____ City _____ State _____

Phone Number (HOME) _____ (CELL) _____

1. First day of your last menstrual period? _____ Are you certain? YES NO
2. Is this a planned pregnancy? YES NO
3. Are you happy with the pregnancy? YES NO
4. Current HEIGHT _____ WEIGHT _____
5. Do you have any medication ALLERGIES? YES NO
If yes, what are you allergic to and what happens? _____

SINCE YOUR LAST MENSTRUAL PERIOD

6. Have you had any vaginal bleeding or spotting? YES NO
Did you have bleeding as much as a period? YES NO Spotting only? YES NO
How often have you had the bleeding/spotting? _____
7. Have you had any nausea? Occasional Frequent None Vomiting? Occasional Frequent None
8. Have you had any breast tenderness? YES NO
9. Have you had any abdominal pain? YES NO
10. Have you had any vaginal discharge? YES NO
11. Have you had any headaches? YES NO
12. Have you had a fever above 101 degrees? YES NO
13. Have you had any illnesses? YES NO
14. Have you had any x-rays? YES NO
15. Have you taken any non prescription medications? YES NO If yes, please circle below:
Tylenol Ibuprofen Aspirin Advil Sudafed NyQuil Tums Maalox Mylanta Pepto Bismal Other _____
16. Have you taken any prescription medications? YES NO If yes, list: _____
17. Are you?
Please circle one: Married Single Widowed Divorced Separated In Relationship

18. FATHER OF BABY

Name _____

Race _____

Age _____

Occupation _____

19. HAVE YOU EVER BEEN SEEN HERE? YES NO

If so, when? _____

Have you ever been seen here using another name?

YES NO

If yes, what was the name? _____

20. Who do you live with? _____
 Do you have any pets? YES NO If yes, what type? _____
21. Do you work outside the home? YES NO
 If yes, do you work FULL TIME PART TIME
 What type of work do you do? _____
22. What is your HIGHEST level of education? _____
23. What is your race? _____
24. Do you have any religious preference? _____
25. Do you exercise on a regular basis? YES NO What type of exercise? _____
26. Are you currently in a monogamous relationship? (only one sex partner) YES NO
 Or do you have multiple sex partners? YES NO
27. Have you used any type of birth control in the past year? YES NO
 Circle all that apply
 Birth Control Pills When did you STOP taking them? _____
 Depo Provera Shot When was your last Shot? _____
 Condoms Other: IUD Nexplanon NuvaRing Dates removed: _____
28. Do you smoke? YES NO CURRENTLY how many per day? _____
 FORMER date stopped _____ NEVER
 Does anyone in the home smoke? YES NO If yes: Inside Outside
29. Do you drink alcohol CURRENTLY? YES NO FORMER date stopped _____ NEVER
30. Have you used any street drugs? YES NO
 If yes, what type? _____ Date last used? _____
31. Do you wear your seat belt? ALWAYS OCCASIONALLY RARELY NEVER
32. Do you feel safe in your personal relationship? _____

FAMILY HISTORY check all that apply

- | | | | | | |
|----------------|---|--|--|---|----------------------------------|
| MOTHER | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> deceased <input type="checkbox"/> alive | <input type="checkbox"/> alzheimers | <input type="checkbox"/> anemia | <input type="checkbox"/> asthma |
| | <input type="checkbox"/> blood clot in legs | <input type="checkbox"/> cancer (type and age diagnosed) _____ | | | |
| | <input type="checkbox"/> depression | <input type="checkbox"/> diabetes type 1 or 2 | <input type="checkbox"/> gallbladder disease | <input type="checkbox"/> gallstones | <input type="checkbox"/> lupus |
| | <input type="checkbox"/> hearing problems | <input type="checkbox"/> hep B | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney disease | <input type="checkbox"/> TB |
| | <input type="checkbox"/> migraines | <input type="checkbox"/> obesity | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> psychiatric problems | |
| | <input type="checkbox"/> scleroderma | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid (hyper or hypo) | | <input type="checkbox"/> Unknown |
| FATHER | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> deceased <input type="checkbox"/> alive | <input type="checkbox"/> alzheimers | <input type="checkbox"/> anemia | <input type="checkbox"/> asthma |
| | <input type="checkbox"/> blood clot in legs | <input type="checkbox"/> cancer (type and age diagnosed) _____ | | | |
| | <input type="checkbox"/> depression | <input type="checkbox"/> diabetes type 1 or 2 | <input type="checkbox"/> gallbladder disease | <input type="checkbox"/> gallstones | <input type="checkbox"/> lupus |
| | <input type="checkbox"/> hearing problems | <input type="checkbox"/> hep B | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney disease | <input type="checkbox"/> TB |
| | <input type="checkbox"/> migraines | <input type="checkbox"/> obesity | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> psychiatric problems | |
| | <input type="checkbox"/> scleroderma | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid (hyper or hypo) | | <input type="checkbox"/> Unknown |
| BROTHER | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> deceased <input type="checkbox"/> alive | <input type="checkbox"/> alzheimers | <input type="checkbox"/> anemia | <input type="checkbox"/> asthma |
| | <input type="checkbox"/> blood clot in legs | <input type="checkbox"/> cancer (type and age diagnosed) _____ | | | |
| | <input type="checkbox"/> depression | <input type="checkbox"/> diabetes type 1 or 2 | <input type="checkbox"/> gallbladder disease | <input type="checkbox"/> gallstones | <input type="checkbox"/> lupus |
| | <input type="checkbox"/> hearing problems | <input type="checkbox"/> hep B | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney disease | <input type="checkbox"/> TB |
| | <input type="checkbox"/> migraines | <input type="checkbox"/> obesity | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> psychiatric problems | |
| | <input type="checkbox"/> scleroderma | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid (hyper or hypo) | | <input type="checkbox"/> Unknown |
| SISTER | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> deceased <input type="checkbox"/> alive | <input type="checkbox"/> alzheimers | <input type="checkbox"/> anemia | <input type="checkbox"/> asthma |
| | <input type="checkbox"/> blood clot in legs | <input type="checkbox"/> cancer (type and age diagnosed) _____ | | | |
| | <input type="checkbox"/> depression | <input type="checkbox"/> diabetes type 1 or 2 | <input type="checkbox"/> gallbladder disease | <input type="checkbox"/> gallstones | <input type="checkbox"/> lupus |
| | <input type="checkbox"/> hearing problems | <input type="checkbox"/> hep B | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney disease | <input type="checkbox"/> TB |
| | <input type="checkbox"/> migraines | <input type="checkbox"/> obesity | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> psychiatric problems | |
| | <input type="checkbox"/> scleroderma | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid (hyper or hypo) | | <input type="checkbox"/> Unknown |

AUNT

<input type="checkbox"/> wears glasses/contacts	<input type="checkbox"/> deceased <input type="checkbox"/> alive	<input type="checkbox"/> alzheimers	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma
<input type="checkbox"/> blood clot in legs	<input type="checkbox"/> cancer (type and age diagnosed) _____			
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes type 1 or 2	<input type="checkbox"/> gallbladder disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> lupus
<input type="checkbox"/> hearing problems	<input type="checkbox"/> hep B	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> migraines	<input type="checkbox"/> obesity	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> psychiatric problems	
<input type="checkbox"/> scleroderma	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid (hyper or hypo)		<input type="checkbox"/> Unknown

UNCLE

<input type="checkbox"/> wears glasses/contacts	<input type="checkbox"/> deceased <input type="checkbox"/> alive	<input type="checkbox"/> alzheimers	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma
<input type="checkbox"/> blood clot in legs	<input type="checkbox"/> cancer (type and age diagnosed) _____			
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes type 1 or 2	<input type="checkbox"/> gallbladder disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> lupus
<input type="checkbox"/> hearing problems	<input type="checkbox"/> hep B	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> migraines	<input type="checkbox"/> obesity	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> psychiatric problems	
<input type="checkbox"/> scleroderma	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid (hyper or hypo)		<input type="checkbox"/> Unknown

MATERNAL GRANDMOTHER
(your mom's mom)

<input type="checkbox"/> wears glasses/contacts	<input type="checkbox"/> deceased <input type="checkbox"/> alive	<input type="checkbox"/> alzheimers	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma
<input type="checkbox"/> blood clot in legs	<input type="checkbox"/> cancer (type and age diagnosed) _____			
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes type 1 or 2	<input type="checkbox"/> gallbladder disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> lupus
<input type="checkbox"/> hearing problems	<input type="checkbox"/> hep B	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> migraines	<input type="checkbox"/> obesity	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> psychiatric problems	
<input type="checkbox"/> scleroderma	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid (hyper or hypo)		<input type="checkbox"/> Unknown

MATERNAL GRANDFATHER
(your mom's dad)

<input type="checkbox"/> wears glasses/contacts	<input type="checkbox"/> deceased <input type="checkbox"/> alive	<input type="checkbox"/> alzheimers	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma
<input type="checkbox"/> blood clot in legs	<input type="checkbox"/> cancer (type and age diagnosed) _____			
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes type 1 or 2	<input type="checkbox"/> gallbladder disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> lupus
<input type="checkbox"/> hearing problems	<input type="checkbox"/> hep B	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> migraines	<input type="checkbox"/> obesity	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> psychiatric problems	
<input type="checkbox"/> scleroderma	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid (hyper or hypo)		<input type="checkbox"/> Unknown

PATERNAL GRANDMOTHER
(your dad's mom)

<input type="checkbox"/> wears glasses/contacts	<input type="checkbox"/> deceased <input type="checkbox"/> alive	<input type="checkbox"/> alzheimers	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma
<input type="checkbox"/> blood clot in legs	<input type="checkbox"/> cancer (type and age diagnosed) _____			
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes type 1 or 2	<input type="checkbox"/> gallbladder disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> lupus
<input type="checkbox"/> hearing problems	<input type="checkbox"/> hep B	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> migraines	<input type="checkbox"/> obesity	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> psychiatric problems	
<input type="checkbox"/> scleroderma	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid (hyper or hypo)		<input type="checkbox"/> Unknown

PATERNAL GRANDFATHER
(your dad's dad)

<input type="checkbox"/> wears glasses/contacts	<input type="checkbox"/> deceased <input type="checkbox"/> alive	<input type="checkbox"/> alzheimers	<input type="checkbox"/> anemia	<input type="checkbox"/> asthma
<input type="checkbox"/> blood clot in legs	<input type="checkbox"/> cancer (type and age diagnosed) _____			
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes type 1 or 2	<input type="checkbox"/> gallbladder disease	<input type="checkbox"/> gallstones	<input type="checkbox"/> lupus
<input type="checkbox"/> hearing problems	<input type="checkbox"/> hep B	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> migraines	<input type="checkbox"/> obesity	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> psychiatric problems	
<input type="checkbox"/> scleroderma	<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid (hyper or hypo)		<input type="checkbox"/> Unknown

FAMILY HISTORY FOR YOU AND THE FATHER OF THE BABY

Genetic disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	Type _____
Twins	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Down Syndrome	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Cystic Fibrosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Blood disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	Type _____
Neural Tube Defects	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Tay-Sachs	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Muscular Dystrophy	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Seizure	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
3 or more miscarriages	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Multiple Sclerosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Stillborn babies	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	
Other inherited genetic/chromosomal disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, who? _____	

YOUR PAST MEDICAL HISTORY

- Chemical abuse YES NO
- Surgery YES NO
- Trauma YES NO
- Transfusion YES NO
- Diabetes Mellitus YES NO
- Stroke YES NO
- High blood pressure YES NO
- Thyroid disease YES NO
- Cardiac disease YES NO
- Multiple gestation YES NO
- Gallbladder disease YES NO
- Bleeding disorder YES NO
- Anemia YES NO
- TB YES NO
- Cancer YES NO
- Asthma YES NO
- Renal disease YES NO
- Recurrent UTI's (3 or more per year) YES NO
- Migraines YES NO
- Decreased Hearing YES NO
- Decreased Vision YES NO
- Hepatitis B YES NO
- Colitis YES NO
- Seizure disorder YES NO
- Psychiatric disorder YES NO
- Do you wear glasses or contacts? YES NO
- STD YES NO

If yes, what type: Chlamydia Gonorrhea Herpes Syphilis Condyloma

What years were you treated? _____

SURGICAL HISTORY

List all surgeries and dates of surgery

PAST GYNECOLOGIC HISTORY

Age you had your first period _____

Are your periods regular? YES NO

How many days between periods? 21 days or less 28-31 days 35 days or more Other _____

How many days does each period last? _____

Is your flow LIGHT MODERATE HEAVY

GYN surgery? YES NO If yes, type and date _____

Abnormal PAP YES NO If yes, when? _____

When was your last PAP? _____

Uterine Anomaly YES NO

Infertility YES NO



WOMEN'S MEDICAL CENTER PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

DATE: _____

Patient Legal Name _____

If Minor, Parent or Legal Guardian Name _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Birth Date _____

Cellular Phone _____ Social Security # _____

Message Phone _____ Referred by _____

Patient employed by _____ Occupation _____

Business Phone _____ Are calls allowed? Yes No

Emergency Contact (not at same number) _____ Phone _____

Marital Status Single Married Widowed Divorced Separated

Race American Indian Asian Black or African American Native Hawaiian White Other

Ethnicity Hispanic or Latino Non Hispanic or Latino Primary language _____

INSURANCE INFORMATION

PRIMARY INSURANCE: Name of Insurance Company: _____

Address of Insurance Company _____

Insurance Number _____ Group # _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ Birth Date _____ Social Security # _____

Employed by: _____ Business Phone _____

SECONDARY INSURANCE Name of Insurance Company: _____

Address of Insurance Company _____

Insurance Number _____ Group # _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ Birth Date _____ Social Security # _____

Employed by: _____ Business Phone _____

DO YOU HAVE AN ADVANCE DIRECTIVE? Yes No

If no, would you like information on it? Yes No

AUTHORIZATION OF CARE

Authorization is given to Women's Medical Center, its providers and employees to provide services and administer provider orders. Certain procedures require a separate consent form.

Patient signature AND legal guardian signature (if patient is a minor) Date

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician/provider for services. Failure to pay any balance due by the undersigned may involve a collection agency or attorney. It is understood and agreed that reasonable attorney fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, agrees to pay all charges not paid in full to Women's Medical Center by a third-party payer.

Patient signature AND legal guardian signature (if patient is a minor) Date



OBSTETRICS | GYNECOLOGY | GYNECOLOGIC SURGERY

2000 W. 21st St., Suite A-1, Clovis, NM 88101 | 575-762-8055 | www.womensmedicalofclovis.com

Date: _____

Name: _____ DOB: _____

How may we contact you?

(Please check and fill out your contact information for all that apply)

HOME PHONE: _____

CELL PHONE: _____

VOICE MAIL/ANSWERING MACHINE

EMAIL: _____

Checking the above information gives Women's Medical Center, LLP permission to call you and/or leave a message. This also gives the doctor or representative permission to give you results via phone; we will not leave test results on a voice mail or answering machine without further permission.

Patient Signature: _____



“Consent to Use and Disclosure of Protected Health Information”

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Women’s Medical Center, LLP or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Women’s Medical Center, LLP may or may not agree to restrict the use or disclosure of your protected health information

If Women’s Medical Center, LLP agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You make revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Women’s Medical Center, LLP reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Women’s Medical Center, LLP to use and disclose my health information in accordance with it.

Name of Patient (Print or Type) _____

Signature of Patient _____

Date _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____



“Notice of Privacy Practices”

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

PLEASE REVIEW THIS CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Women’s Medical Center, LLP. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be used to disclose to enforcement agencies, without permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s public health department.

Other uses and disclosures requiring your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information.

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive a printed copy of this notice

Women's Medical Center Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require the requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Lonnie Ray, Privacy Officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to:

Lonnie Ray, Privacy Officer
Women's Medical Center, LLP
2000 W. 21st St., Suite A-1
Clovis, NM 88101

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against by filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Lonnie Ray, Privacy Officer
Women's Medical Center, LLP
2000 W. 21st St., Suite A-1
Clovis, NM 88101

Effective Date

This Notice is effective April 14, 2003.