New Patient Information

Advanced Menstrual Care Center ©

Control your period. Improve your life!

Dr. Steven W. Tucker, ACGE, FACOG
Medical Director

Dr. Steven W. Tucker is Medical Director of Advanced Menstrual Care Center (AMCC). AMCC provides comprehensive women's healthcare.

AMCC specializes in the care of women with abnormal menstrual cycles including abnormal bleeding, menstrual pain, painful sex, and endometriosis.

Dr. Tucker has over 35 years experience in women's healthcare. He was in the first group of physicians to be credentialed in advanced, minimally-invasive surgery including CO2, KTP, Nd:YAG, and Argon laser surgery. He was also one of the first OB/GYN's to introduce office hysteroscopy. We are committed to caring for you with compassion, expertise, and service.

Your First Visit

During your first visit, you will meet Dr. Tucker and the AMCC staff, Tiffani and Tyra. This visit includes a complete history and physical exam. Additional services such as pap smear, cultures, pregnancy testing, and ultrasound may be provided at this visit.

AMCC strives to provide comprehensive services, and Dr. Tucker focuses training and resources on diagnosing and treating patients in a faster interval of time. To accelerate how quickly patients move from initial visit to resolution of their bleeding disorders, AMCC offers almost all procedures in the office.

Getting Ready

Please bring the following items to your first visit:

A. Identification;

B. Medical insurance card;

C. A list of all medications including supplements and OTC medications;

D. Completed medical history (attached);

E. List of all doctors and facilities including phone numbers and addresses; and,

F. Any applicable payments.

Your Privacy, Our Priority

To ensure patient privacy, all initial patient visits begin with an introductory visit with the medical assistant and Dr. Tucker in private. After this initial introduction, the patient may invite visitors for completion of the history and examination.

Financial Policy

Payment is due at the time of service. Our office accepts major credit cards, checks, and cash. AMCC accepts most major insurances.

We Are Here to Help You

Please call, fax, or email our office for questions or problems including financial counseling, interpreter services, directions, or other concerns. For emergencies, Dr. Tucker can be reached at (410) 337-AMCC (2622).

ADVANCED
MENSTRUAL CARE CENTER, LLC

8601 La Salle Road
Suite 104
Towson, MD 21286-2005

Tel: (410) 337-AMCC (2622)
Fax: (410) 321-5493

PARTNERS IN HEALTH FOR YOUR GOOD

My staff and I are pleased to have the opportunity to partner with you in fulfilling our mission to “enable every woman to choose the menstrual life they deserve”.

As we work towards this mission, we will help our patients while pursuing our vision: “To empower, educate, and inform women so they can live their ideal life.”

Your satisfaction is the measure of our success in helping you reach your healthcare goals.

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New Patient Welcome

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Menstrual Care Center

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PATIENT REGISTRATION FORM

Patient Name:____
Last Name First Name Middle Initial

Date of Birth:__________________ Sex: Female Transgender Marital Status: Married Single Divorced Widow

Address:____
Street City State Zip

Home Phone:__________________ Work Phone:__________________ Cell Phone:__________________

Email Address:__________________________ Preferred method of contact: Home Cell (Call) Text Mail Email

Employment Status(Circle One): Full-Time Part-Time Student Unemployed Self-Employed Retired

Employer/School:____

Primary Care Physician:______________________________ Phone:__________________
First & Last Name

Emergency Contact:______________________________ Phone:__________________
First & Last Name Relationship

Pharmacy:______________________________ Phone:__________________
Name Address

How did you hear about Advanced Menstrual Care Center?__________________________

PRIMARY INSURANCE COVERAGE

Insurance Company:____

Policy Number:__________________ Group Number:__________________ Eff. Date:____________

Insured's Name:__________________ DOB:____________ Relationship to Patient:__________________

Insured's Address:______________________________ Employer:__________________

SECONDARY INSURANCE COVERAGE

Insurance Company:____

Policy Number:__________________ Group Number:__________________ Eff. Date:____________

Insured's Name:__________________ DOB:____________ Relationship to Patient:__________________

Insured's Address:______________________________ Employer:__________________

I authorize Advanced Menstrual Care Center LLC to apply for benefits on my behalf for services rendered by Dr. Steven W. Tucker. I request payment from my insurance company be made directly to Advanced Menstrual Care Center LLC. I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claims. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

____ __________________

Signature of Patient/Guardian Date

Name:____ Appointment Date:________________

Birthdate: __________________ Age:_________ Sex (please circle one): Female Transgender

This form is a part of your medical record. Please be accurate and complete. If changes or modifications are required, please inform any member of our staff so we may update your records. A page can be added for explanations.

Reason for this visit

Expectations & desired outcome

Current Medications, Supplements, and OTC Therapy

Check here if none ☐

Name	Dose	How often	Reason

Medical History

List current and chronic health problems. **Check here if none** ☐

Problem/Concern	Active? ☑	Diagnosis Date	Treatment(s)

Allergies to Drugs, Medications, Nuts, Foods, or Latex

Check here if none ☐

Allergy	Reaction	Comments

Gyn History

Age of first period? __________ Days between periods? _________ Length of flow? _____________

Pads/Tampons per day? _______________ Clots? Yes ☐ No ☐ Pain? Yes ☐ No ☐

First day of last period? ___________Prior period? ___________Are periods regular? Yes ☐ No ☐

Current Birth Control Method

Check all that apply. **Check here if none** ☐

Condoms ☐ Pills ☐ IUD ☐ Depo Provera ☐ Nexplanon ☐ Diaphragm ☐ Foam ☐

Essure ☐ Vasectomy ☐ Tubal Ligation ☐ Other____

Pap Smear History

Check here if none ☐

Date of last pap? _____________ Result?__________________ HPV Positive ☐ HPV Negative ☐

Any abnormal pap smears? Yes ☐ No ☐ (If Yes, please indicate date)___________________________

Did you receive Gardasil HPV vaccine? Yes ☐ No ☐ Did you complete it? Yes ☐ No ☐

Name:______________________________________ DOB:________________ Date:_________

Sexual History

Check here if none ☐

Are you currently sexually active? Yes ☐ No ☐ Number of partners in last 12 months?________

Total sex partners _________ # of opposite sex partners ______ # of same sex partners _______

Sexually Transmitted Infection History? Yes ☐ No ☐ Please list (diagnosis, date, & treatment):

Screening Test History

Check here if none ☐

Test Performed	Date	Result	Comments
Mammogram			
Colonoscopy			
Bone density			
Other (describe)			

Pregnancy History

Check here if none ☐

Pregnancy	Number	Date	Comments
Full term vaginal deliveries			
Full term c-section deliveries			
Preterm vaginal deliveries			
Preterm C-section deliveries			
Miscarriages			
Abortions			
Ectopic pregnancy(s)			
Children living			
Adopted			

Surgery History

Check here if none ☐

Date	Type of Surgery	Hospital/ASC City & State	Result & Comments

Hospital & Psychiatric Admission History

Check here if none ☐

Date	Hospital	City & State	Reason for Admission

Name:______________________________________ DOB:________________ Date:_________

Family History

Check ☑ the history that applies for each family member.

	Age	Ovarian Cancer	Breast Cancer	Colon Cancer	Diabetes	High Blood Pressure	Heart Disease	Stroke	Blood Clots	Comments
Mother										
Father										
Siblings										
Children										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Siblings (number): Brothers ____ Sisters ________

Children (number): Sons _______ Daughters ______

Social History

Activity	Comments
Birthplace?	
Education?	
Employment?	
Military?	
Incarceration?	
International Travel: Where, When?	
Home: Rent, Own?	
Household Residents:	
Pets?	

Activity	✓	Type, Amount & Frequency	Comments
Drink alcohol?			
Use tobacco?			
Use street drugs?			
Exercise?			
Diet?			
Family activities?			
Hobbies?			
Religious/Spiritual?			
Volunteer?			

Other concerns you wish addressed at this consultation:

How did you learn about this practice?

How may we improve our service to you?

Advanced Menstrual Care Center
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Date:________________

Name:____ Birthdate:__________________________

Review of Systems

The review of systems is a routine part of any complete medical history. It is confidential and becomes an important part of your medical record. This questionnaire searches for subtle signs of problems that may require further evaluation. Please note that a healthy person will have many of these symptoms intermittently. Those symptoms that are persistent, recurrent, or severe are the most important in a patient's history. Please circle all symptoms that apply to you, or check the box, "No Concerns", if none of the symptoms apply.

Body System	Symptoms (Please Circle All That Apply)	No Concerns ☑	Comments
General Health	Excessive fatigue | Unexplained weight loss | Excess weight gain | Loss of appetite | Fever | Night sweats | Insomnia		
Heart & Vessels	Palpitations | Irregular heartbeat | Racing heart | Chest pain | Persistent swelling of legs | Pain in legs when walking | Sleeping on 2 or more pillows | Frequent dizziness | Cold hands or feet		
Lungs & Airways	Shortness of breath | Wheezing | Difficulty catching breath | Frequent, chronic coughing | Coughing up blood | Coughing up sputum | Pain on breathing | Prior TB | TB exposure | Oxygen therapy | Abnormal X-rays		
Ears, Nose, Throat	Difficulty hearing | Ear pain | Ear discharge | Chronic runny nose | Post-nasal drip | Chronic nasal congestion | Sinus pain | Ringing in ears | Nosebleeds | Sore throat | Hoarseness | Facial pain or numbness | Eye pain | Tunnel vision | Floaters | Bleeding gums | Dental problems | Dentures | Partial plates | Contacts | Other implants of any type		
Intestinal Tract	Heartburn | Constipation | Frequent diarrhea | Black stools | Bloody stools | Frequent vomiting | Bloody vomit | Abdominal pain | Leaking stools | Painful bowel movements | Change in bowel movements | Jaundice | Loss of appetite | Loss of taste		
Kidneys & Bladder	Painful urination | Leaking urine | Bloody urine | Prior kidney or bladder infections | Painful urination | Urinary frequency | Urgency of urine | Discolored urine		
Muscle & Bones	Joint pain | Joint swelling | Difficulty moving joints | Aching muscles | Knots on skin, joints or muscles		
Skin, Hair & Breasts	Persistent rash | Chronic itching | Changing moles | Chronic ulcers | Draining ulcers | Poor wound healing | Hair loss | Excessive hairiness |		
Brain & Nerves	Frequent headaches | Blurred vision | Double vision | Loss of vision | Difficulty walking | Difficulty with balance | Falling | Dizziness | Tremor | Numbness or loss of sensation | Weakness of a body part or area |		
Glands	Intolerance to heat or cold | Excess hunger | Excess thirst | Menstrual irregularities		
Blood & Lymph	Easy bruising or bleeding | Difficulty stopping bleeding | Anemia | Swollen lymph glands | Prior blood clots to lungs or other areas		
Immune System	Seasonal allergies | Frequent infections | History of or risk for HIV | Severe allergic reactions		
Psychiatric	Current or prior depression | Prior psychiatric diagnosis or treatment | Suicidal thoughts | Homicidal thoughts |Mood swings | Compulsions | Anxiety | Obsessive thoughts | Hallucinations | Memory loss		
Women's Health	Painful sex | Painful periods | Menstrual clots | Missing periods | Heavy periods | Infertility | Breast pain | Breast lump | Breast discharge		

Comments:____
____
____
____

Use and Disclosure of Protected Health Information (PHI)

Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Advanced Menstrual Care Center LLC may use and disclose protected health information (PHI) about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date at the Advanced Menstrual Care Center LLC location.

You have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our ***Notice of Privacy Practices***.

____ _______________

Patient's Signature Date

____

Print Full Name

Section II (Optional):

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION (PHI) TO BE USED AND/OR DISCLOSED

Name or specifically identify those persons and/or other entities you are authorizing to make use of and/or to disclose your PHI regarding treatment, payment, and other healthcare operations.

____ _______________

Name of Authorized Person or Entity Relationship

____

Phone #

____ _______________

Name of Authorized Person or Entity Relationship

____

Phone #

____ _______________

Patient's Signature Date

____

Print Full Name

Section III: AUTHORIZATION FOR USE OF VOICEMAIL

The Advanced Menstrual Care Center LLC physician and healthcare staff are routinely unable to contact patients directly during normal business hours. On these occasions, our office leaves messages on communication devices provided by our patients. Due to the federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. PHI that we may possibly disclose on your home, work, or cell phone would include but is not limited to test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and procedure posting/scheduling information.

1. _____ (Initial) Yes, I agree to allow the Advanced Menstrual Care Center LLC physician and healthcare staff to leave messages that include PHI on all three communication devices: home, work, and cell phone.
2. _____ (Initial) I agree to allow the Advanced Menstrual Care Center LLC physician and healthcare staff to leave messages that include PHI on the following: (Please initial next to the applicable communication devices.)

   _____Home Phone _____ Work Phone _____ Cell Phone

3. _____ (Initial) No, I do not agree to allow Advanced Menstrual Care Center LLC physician and healthcare staff to leave messages that include PHI on my home, work, or cell phone.

____ _______________

Patient's Signature Date

____

Print Full Name

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact Advanced Menstrual Care Center. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

For AMCC Internal Use Only

Section IV: UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed notice receipt acknowledgement from the patient for the following reason:

____

____

Option 2: I attempted to obtain a signed notice receipt acknowledgement from the patient on ___/___/___, but was unable for the following reason:

____

____

____ __________________

AMCC Employee Signature Date

Authorization for Release of Health Information

Revocation (if requested)
Date Revoked:__________________

Patient Name: ____ **Birthdate:** _______________________

Address: ____

City: _______________________________ **State:** _______ **Zip:** _________ **Phone:** ______________________________

Email: ____ **MR#:** ________________________________

I authorize Advanced Menstrual Care Center LLC to take the following action(s):

REASON FOR REQUEST (CHECK ✓ONE):

☐ At request of the patient ☐ For my care/treatment ☐ For legal reasons ☐ For payment/insurance reasons

ACTION REQUESTED (CHECK ✓ ONE):

☐ Provide a copy of identified health information to patient.
☐ I wish to review my health information. I do not want a copy.
☐ Release patient's identified health information to:
☐ Discuss patient's identified health information with:
☐ Obtain patient's identified health information from:

For Office Use Only

____
Name of person or entity

____
Address

____ **Fax:** ___________________________
City State Zip

INFORMATION REQUESTED (CHECK ✓ ALL THAT APPLY): ☐ Billing Record(s) ☐ Substance Abuse __________ (Initial)

☐ Abstract (Discharge Summary, Admission History & Physical, Operative Report(s), Pathology Report(s), Diagnostic Testing) ☐ Operative Report ☐ Pathology Report ☐ Admission History & Physical ☐ Discharge Summary

☐ Diagnostic Testing (Lab Reports, X-Rays, CT Scans, MRI, Ultrasounds, etc.) ☐ Immunization Record(s)

☐ Progress Note(s) ☐ Mental Health Record(s) ☐ Infectious Record(s), (______ Include ______ Exclude HIV/AIDS)
(Initial) (Initial)

☐ Radiology/Procedure Images ☐ All Records ☐ Pap Smear Results

RECORDS REQUESTED FOR PERIOD: FROM:_________________ TO _____________________.

Signature:____ **Date:**_____________________

Rev20181102

Authorization for Release of Health Information

Patient Name: ____Birth Date: ______________________

I understand and agree that I am responsible for the security and confidentiality of all Personal Health Information which is transferred to my possession. I take responsibility for securing this information in a manner consistent with recommended practices, including but not limited to, encryption, physical access and security control, secure transmission techniques etc. I further understand that standard email, texting, cellular transmission and internet transmission are not secure. Additional risks including misdirection, misaddressing, message forwarding, shared email, hacking methods including phishing, transfer to portable devices, etc. I acknowledge and accept these risks and others, known and unknown.

I further understand that:

- **This authorization is voluntary. My treatment will not be affected whether I sign this authorization or not.**
- **This authorization is valid for one year from date signed unless I revoke this authorization or unless an earlier date is specified here: ____________________________.**
- **I may revoke this authorization at any time, except to the extent that action has been taken prior to receipt of the revocation. I must submit my request to revoke this authorization in writing to Advanced Menstrual Care Center LLC.**
- **Once my health information is disclosed as requested, it may be subject to redisclosure by the person(s) receiving it and may no longer be protected by federal and state privacy laws.**
- **The medical information released may contain information related to HIV status, AIDS, sexually transmitted infections, mental health, drug and alcohol abuse, genetic disorders, etc.**
- **Advanced Menstrual Care Center LLC will not condition the provision of treatment or payment on the provision of this authorization.**

FORMAT REQUESTED:

☐ On paper in person ☐ On paper via mail ☐ By encrypted email

Patient Signature: ____ Date: _________________

HIPAA Notice of Privacy Practices

Effective 08/01/2018

NOTICE OF INFORMATION PRACTICES AND PRIVACY: 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.

OUR OBLIGATIONS:

We are required by law to:
- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose Protected Health Information that identifies you ("PHI"). Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our practice.

For Treatment: We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose PHI so that we, or others, may bill and receive payment from you, and insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

SPECIAL SITUATIONS:

As Required by Law: We will disclose PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Organ and Tissue Donation: If you are an organ donor, we may use or release PHI to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or issue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose PHI for public health activities. The activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and, the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Business Associates: To third parties referred to as "business associates" that provide services on our behalf, such as billing, software maintenance, and legal services.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT:

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify your PHI that directly relates to that person's involvement in your health care excluding specific PHI. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes; and,

2. Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You may revoke it at any time by submitting a written revocation to our Privacy Officer, and we will no longer disclose PHI under the authorization. However, disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Protected Health Information (PHI) we have about you:

Right to Inspect and Copy: You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this PHI, you must make your request in writing to **Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.**

We have up to 30 days to make your PHI available to you, and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your PHI is maintained in an electronic format (known as an electronic medical record (EMR) or an electronic health record (EHR), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend: If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to **Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.**

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment, or health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing to **Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.**

Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care like a family member or friend. For example, you could ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to **Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.**

We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes, and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI, with respect to that item or service, not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request in writing **to Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.** Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice on our website www.advancedmenstrualcarecenter.com. To obtain a paper copy of this notice, please contact **Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.**

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact **Practice Manager, Advanced Menstrual Care Center, 8601 La Salle Road, Ste 104, Towson, MD 21286-2005.**

All complaints must be made in writing. **You will not be penalized for filing a complaint**.