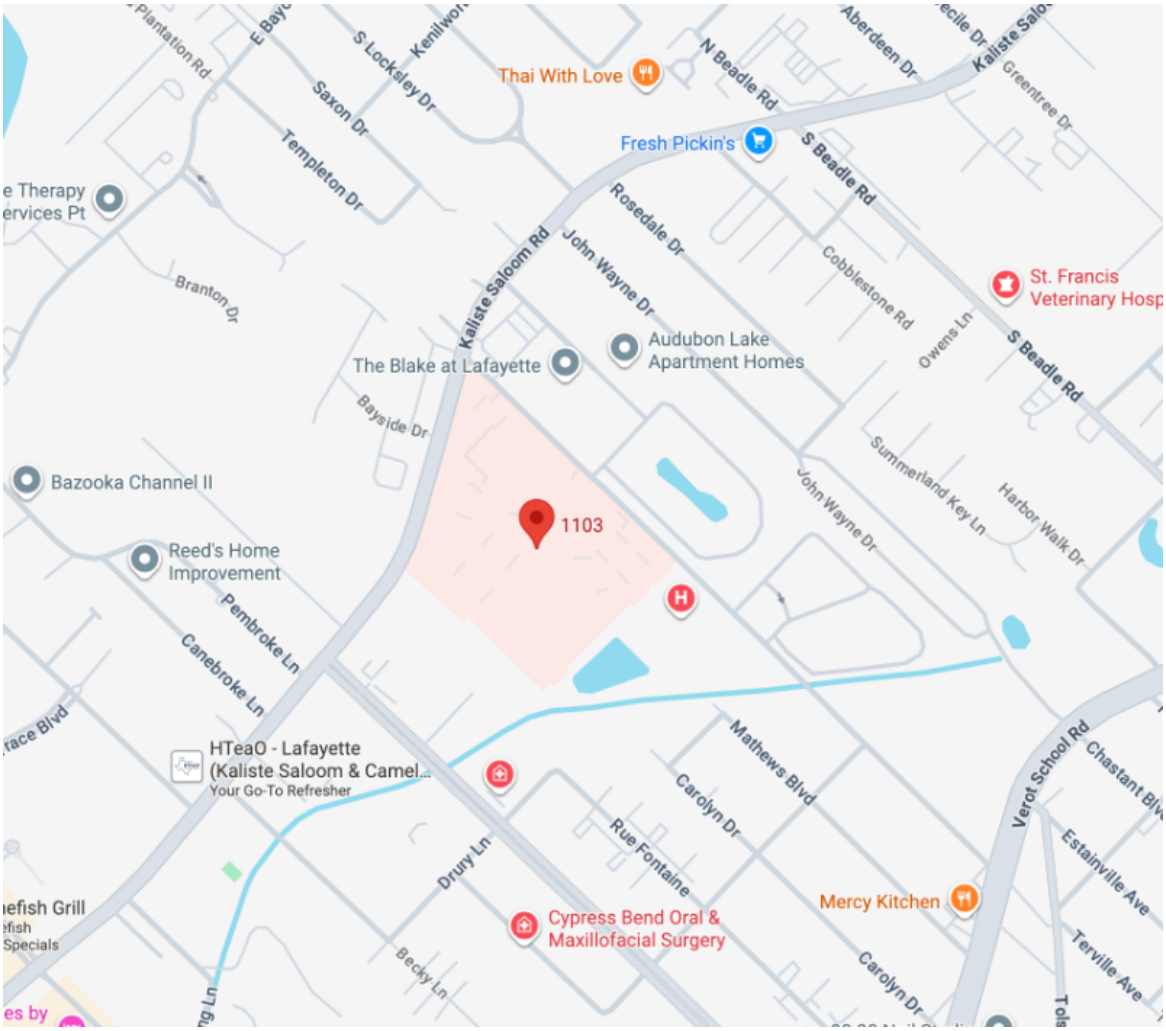
LAFAYETTE OBGYN

Mary L. Laville, M.D.



1103 Kaliste Saloom Rd
Suite 304
Lafayette, LA 70508

(337) 962-1334

Please arrive at least 15 minutes prior to scheduled appointment time. All New Patient paperwork must be COMPLETED prior to your arrival. Have your insurance card(s), pictured ID or driver's license and payment for services available at each appointment. We look forward to seeing you at your appointment.

LAFAYETTE OBGYN

MARY L. LAVILLE, M.D.

Please print clearly *DATE:*_____

*REFFERED BY:*_____

PATIENT INFORMATION:

PATIENT NAME: _____
(*First*) *(M.)* *(Last)*

ADDRESS:_____
City State ZIP

BIRTH DATE:_____/____/_____AGE_____MARITAL STATUS_____GENDER_____

HOME PHONE:_____CELL #_____WORK#_____

SOCIAL SECURITY#_____EMAIL ADDRESS_____

EMPLOYER:_____OCCUPATION:_____

EMERGENCY CONTACT NAME:_____PHONE#_____

RESPONSIBLE PARTY/ GUARANTOR INSURANCE INFORMATION:

NAME:_____SOCIAL SECURITY #_____

ADDRESS:_____
City StateZIP

BIRTH DATE:_____/_____/_____EMPLOYER:_____

RELATIONSHIP TO PATIENT:_____CELLPHONE:_____

PRIMARY INSURANCE:_____SUBSCRIBER NAME:_____

POLICY NUMBER:_____GROUP #_____

SECONDARY INSURANCE:_____SUBSCRIBER NAME_____

POLICY NUMBER:_____GROUP #_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plan to Mary L. Laville, MD. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I fully understand that all delinquent accounts are subject to any additional expenses such as collections fee and/or attorney fees. **ALL FEES MUST BE PAID AT THE TIME OF SERVICE.**

SIGNATURE OF PATIENT_____**DATE**_____

Dr. Mary L. Laville
Office/ Financial Policy Agreement:

I understand that it is my responsibility to know my Insurance benefits. Those services that are deemed non-medically necessary or non-covered will be my responsibility. Please bring your insurance card to all visits.

Payment for services is due at the time of service. This includes co-pays, deductibles, and co-insurance unless you have made payments arrangements with my office manager. We accept cash, check, money order and credit/debit cards. You will be responsible for claims denied or remains unpaid for a period exceeding 60 days. If the account is turned over to collections, you are responsible for all fees associated with collecting unpaid balances.

I understand that it is my responsibility to give new information to our office staff; such as new Insurance cards, new address, new phone number & any name change. Failure to do so can result in claims not being paid and becoming your responsibility.

Appointments: If you are unable to keep your scheduled appointment, please give us 24 hours notice or you will be billed $50.00 for failure to show for appointment. If you are more than 15 minutes late for an appointment, you may be rescheduled.

Calls: All calls will be triaged by the nurse and returned the same business day. All calls regarding lab or procedure results will be called within 7 to 10 business days.

Samples: In all fairness, only one or two sample packs of birth control, hormones, etc. will be given at time of visit. After that, a written script will be given.

All mail order prescriptions are the responsibility of the patient. We will give you a written prescription for you to mail or fax to your company, or you must provide us with the correct form and fax number to fax to your company. We will no longer call your company for forms or to call in a script.

We will no longer call in prescriptions that were already written by Dr. Laville.
All prescriptions will be called in within 24 hours. Please check with your pharmacy before picking up prescriptions. The fastest way to get your medications refilled is to call your pharmacy and ask them to send us a refill request.

Prior authorization for medical/surgical procedures will be done by our office. Prior authorizations for medication will be done according to the discretion of the doctor.

Any forms to be filled out by Doctor must be left at our office at least 5 to 7 working days. There will be a $25.00 fee for all forms requested.

Our office staff can be reached Monday- Thursday 8:00am-12:00pm &1:00pm-5:00pm. Fridays 8:00am-12:00pm.

Please bring a detailed list of all medications to your visit.

Please indicate your agreement with this policy by signing our Receipt of Policies Section of this packet.

ELECTRONIC PAYMENTS

As a small business, we must constantly strive to reduce and minimize our expenses and cost of doing business. Today insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Once the insurance pays, the patient owes their deductible, co-insurance or copay or any non-covered service.

In an effort to streamline this system and make it more cost effective for everyone, we are asking every patient provide us with a credit, HSA or debit card at the time of service. Your information will be secured. This system is exactly like that found in all hotels, rental car companies, gasoline stations, Amazon and PayPal etc. Nothing will be charged to your card until the Explanation of Benefits(EOB) returns from your insurance company, and the payment and contractual write-off are reflected on your account. Our office will contact you for verbal approval prior to charging your card with the amount which is the PATIENT RESPONSIBILITY per your insurance company. This will significantly reduce the cost of repeat statements and collection attempts. As a small business operating on fixed insurance reimbursements with rising cost and expenses, we must do everything possible to reduce the length of time that we extend credit to our patients.

Thank you for your cooperation and understanding.

AUTHORIZATION TO CHARGE MY CREDIT CARD, HSA CARD OR DEBIT CARD FOR THE PATIENT RESPONSIBILITY PORTION PER THE INSURANCE COMPANY FOR SERVICES RENDERED.

I authorize Mary L. Laville, M.D. to charge my credit card, HSA card or debit card with the balance due (patient responsibility) per my insurance explanation of benefits(EOB). I understand that the office will contact me prior to charging my card for verbal approval. I understand that I can dispute the charge at any time with my credit card company, however, the actual amount of the charge can only be disputed with my insurance company if I feel the “patient responsibility” portion on the explanation of benefits (EOB) is incorrect. Any change in the EOB by the insurance company must be sent to the office prior to any credit or additional charge being made to my credit, HSA or debit card.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

Mary L. Laville, M.D.
1025 Kaliste Saloom Rd
Suite 100
Lafayette, LA 70508
Office: 337-993-3933 Fax: 337-993-2689

MARY L. LAVILLE, M.D.
1025 Kaliste Saloom Rd
Suite 100
Lafayette, LA 70508
(337) 993-3933

PERSONAL HISTORY

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to doso.

NAME_____ AGE _____

DATE _____

Were you referred by a physician for this visit? _____

Name and full address of your present physician_____

_____

Reason for your visit? _____

PAST MEDICAL HISTORY

ILLNESSES

Have you ever had:

	NO	YES	YEAR		NO	YES	YEAR
Mumps	☐	☐		Back Trouble	☐	☐	
Scarlet Fever	☐	☐		Blood Disease	☐	☐	
Rheumatic Fever	☐	☐		Anemia	☐	☐	
Diphtheria	☐	☐		Jaundice	☐	☐	
Chicken Pox	☐	☐		Hepatitis	☐	☐	
Tuberculosis	☐	☐		Epilepsy	☐	☐	
Malaria	☐	☐		Migraine Headaches	☐	☐	
Polio	☐	☐		Diabetes	☐	☐	

	NO	YES	YEAR		NO	YES	YEAR
Kidney Stones	☐	☐		Bladder/Kidney Infection	☐	☐	
High Blood Pressure	☐	☐		Colitis/Other Bowel Disease	☐	☐	
Low Blood Pressure	☐	☐		Hemorrhoids/Rectal Disease	☐	☐	
Asthma	☐	☐		Gallbladder Disease	☐	☐	
Hay Fever	☐	☐		Blood Clots	☐	☐	
Pneumonia	☐	☐		Gout	☐	☐	
Pleurisy	☐	☐		Thyroid Disease	☐	☐	
Heart Murmur	☐	☐		Skin Disease	☐	☐	
Heart Attack	☐	☐		Depression	☐	☐	
Irregular Heart Beat	☐	☐		Anxiety	☐	☐	
Stroke	☐	☐		Cancer (List Type)	☐	☐	
Glaucoma	☐	☐		High Cholesterol	☐	☐	
Stomach Ulcer	☐	☐		Other	☐	☐	

INJURIES

Have you had any:

	NO	YES	YEAR		NO	YES	YEAR
Concussion/Head Injury	☐	☐		Dislocations	☐	☐	
Broken/Cracked Bones	☐	☐		Knocked Unconscious	☐	☐	
Lacerations	☐	☐		Blood Transfusion	☐	☐	

HOSPITALIZATIONS

If you have been hospitalized for any illness **EXCLUDING** childbirth and surgeries, please give details

_____

_____

_____

_____

FAMILY HISTORY

Has any blood relative ever had:

	NO	YES	RELATIVE
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Heart Attack	☐	☐	
Thyroid Disease	☐	☐	
Bleeding Problems	☐	☐	
Glaucoma	☐	☐	
Cancer (List Type)	☐	☐	
Depression	☐	☐	
Suicide	☐	☐	
Osteoporosis	☐	☐	

SOCIAL HISTORY

Have you ever used:

	NO	YES	Quantity
Tobacco	☐	☐	
Alcoholic Beverages	☐	☐	
Recreational Drugs	☐	☐	
I.V. Drugs	☐	☐	

PAST SURGICAL HISTORY

Have you ever had:

	NO	YES	YEAR		NO	YES	YEAR
Tonsillectomy	☐	☐		Tubal Ligation	☐	☐	
Appendectomy	☐	☐		Abdominal Hysterectomy	☐	☐	
Removal of Gallbladder	☐	☐		Vaginal Hysterectomy	☐	☐	
D & C	☐	☐		Removal of Ovaries	☐	☐	
Conization of Cervix	☐	☐		Bladder Surgery	☐	☐	
Cryosurgery(Freeze)Cervix	☐	☐		Rectal Surgery	☐	☐	
Laser of Cervix/Vulva/Vagina	☐	☐		Other	☐	☐	
Laparoscopy	☐	☐		Anesthesia Problems	☐	☐	
Thyroid Surgery	☐	☐			☐	☐	

ALLERGIES

Are you allergic to:

	NO	YES	YEAR		NO	YES	YEAR
Penicillin	☐	☐		Demerol	☐	☐	
Sulfa	☐	☐		Aspirin	☐	☐	
Codeine	☐	☐		Ibuprofen	☐	☐	
Morphine	☐	☐		Other	☐	☐	

GYNECOLOGY HISTORY

	NO	YES	COMMENTS
1) Age of first menstrual cycle?	☐	☐	
2) Do you still menstruate?	☐	☐	
3) Age that you stopped menstruating	☐	☐	
4) Are your cycles regular?	☐	☐	
5) Is your flow normal?	☐	☐	
6) Do you bleed for more than 7 days?	☐	☐	
7) Do you bleed between your periods?	☐	☐	
8) Number of pads/tampons used on heaviest day	☐	☐	
9) Date of last menstrual period	☐	☐	
10) Do you have menstrual cramps?	☐	☐	
11) Are your cramps severe?	☐	☐	
12) Do you have cramps when not menstruating?	☐	☐	
13) Any clots passed?	☐	☐	
14) Any ovarian cysts, endometriosis, fibroids?	☐	☐	
15) Any fibrocystic breast disease?	☐	☐	
16) Any dribbling of urine after coughing/sneezing?	☐	☐	
17) Any itching of vaginal area?	☐	☐	
18) Any abnormal vaginal discharge?	☐	☐	
19) Any sexually transmitted diseases?	☐	☐	
20) Are you sexually active?	☐	☐	
21) Do you consider yourself homosexual?	☐	☐	
22) Do you have pain/bleeding with sex?	☐	☐	

	NO	YES	COMMENTS
23) Is your sex life satisfactory?	☐	☐	
24) Do you use birth control? Type?	☐	☐	
25) If menopausal, are you on hormones?	☐	☐	
26) Have you ever been pregnant?	☐	☐	
27) Total number of times pregnant	☐	☐	
28) How many children born alive?	☐	☐	
29) How many stillbirths?	☐	☐	
30) How many miscarriages?	☐	☐	
31) How many terminations?	☐	☐	
32) How many premature births?	☐	☐	
33) How many cesarean sections?	☐	☐	
34) Year of last delivery	☐	☐	
35) Largest baby weighed	☐	☐	
36) Any pregnancy complications? Describe	☐	☐	
37) Date of last Pap Smear	☐	☐	
38) Date of last Mammogram	☐	☐	
39) Date of last Bone Density	☐	☐	
40) Date of last Colonoscopy	☐	☐	

LAFAYETTE OBGYN

Mary L. Laville, M.D.

MEDICATIONS

Patient Name:	DOB:
Allergies:	

Medication Name	Dosage/Frequency	Prescribing Doctor

****Please list all prescription medications, over the counter medications, hormones, and vitamins/supplements.****

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Mary L. Laville, M.D.

1025 Kaliste Saloom Rd
Suite 100
Lafayette, LA 70508
OFFICE: 337-993-3933
FAX: 337-993-2689

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
Physician/Clinic

_____
Address

_____
City State Zip Phone#

PATIENT NAME: _____ DOB: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:
MARY L. LAVILLE M.D.

_____ _____
PATIENT SIGNATURE DATE

PLEASE RELEASE THE FOLLOWING RECORDS:

- ☐ Office Visit/ Telephone Notes
- ☐ Mammogram Results
- ☐ Pap Results
- ☐ Hospital reports
- ☐ Lab/Test Results
- ☐ DEXA(Bone Density)
- ☐ Operative Procedure Reports
- ☐ Prenatal records
- ☐ Ultrasound
- ☐ Other _____

COMMENTS: _____

_____

_____

NOTICE OF PRIVACY POLICY FOR DR. MARY L. LAVILLE

To Our Patients:

Your privacy is important to us, and maintaining your trust and confidence is one of our highest priorities. We respect your right to keep your personal, medical information confidential. A recent law change requires us to disclose our Privacy Policy to you and describe how medical information about you may be used and disclosed. In addition, the policy will explain how you can obtain access to this medical information. We hope that by taking a few moments to read our policy, you will have a better understanding of what we do with the information you provide us and how we keep it private and secure. Please review it carefully.

If you have any questions about any part of this Privacy Policy or if you would like more information about the privacy practices with Mary L. Laville, MD, please contact:

HIPAA Officer
(337) 993-3933

Mary L. Laville, MD collects protected health information from you, the patient. " Protected health information" is information about you which may include demographic information, health information, etc. and relates to your past, present, or future physical or mental health conditions(s) and related care services. This protected information is obtained and stored in a medical chart and/or within our medical computer software. This is "your" medical record. The medical record is the property of MARY L. LAVILLE, MD, but the information in the medical record belongs to you. This Notice of Privacy describes how MARY L. LAVILLE, MD may use and disclose your protected health information to carry out treatment, payment, or health care operations, as well as, for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

MARY L. LAVILLE, MD is required to abide by the terms of this Notice of Privacy. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Upon your request, we will provide you with any revised Notice of Privacy by calling the office and speaking with the HIPAA officer, or requesting the copy by mail.

This Notice of Privacy was published and becomes effective April 14, 2003.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consent to use and disclosure of your protected health information for treatment, payment, and health care operations by signing the consent form, your physician will disclose your protected health information as described in Section I. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also by used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent forms. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

TREATMENT: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may disclose protected health information about you to physicians, nurses, technicians, or other personnel who are involved in taking care of you. They may work at our office, at the hospital if you are hospitalized under our supervision, or at another physician's office, laboratory, pharmacy, or other health care provider to whom we may refer you for consultation, perform laboratory testing, to have prescriptions filled, or for other treatment purposes. For example, we would disclose your protected health information, as necessary, to a home health agency that would provide care to you. We would also disclose your protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom we referred you in order to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information to a specialist physician, laboratory, pathologist, etc. who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

PAYMENT: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party (i.e. attorney). This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you. For example, if an insurance company needs to make a determination of eligibility or coverage for insurance benefits, review services provided to you for medical necessity, and undertake utilization review activities. An example could be obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the insurance carrier in order to receive approval for the hospital admission. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

HEALTH CARE OPERATIONS: Your protected health information may be used or disclosed in order to support the business activities of your physician's practice. These uses and disclosures are necessary to run our practice and make sure that all our patients receive quality care. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, study/research purposes, and conducting or arranging for other business activities.
For example, we disclose your protected health information to medical students that see patients at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (transcription services, electronic transmission of insurance claims, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of you protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment options or alternatives or other health-related benefits and services that may be of interest to you. We may disclose your protected health information if outside storage facilities is utilized. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our HIPAA officer to request these materials not be sent to you.

We may use or disclose your protected health information about you for study/research purposes. For example, a research project may involve comparing the health and recovery of certain patients who received a particular medication to those who received another kind of medicine for the same medical condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' needs for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process; but we may disclose health information about you to people preparing to conduct a research project.

Uses and Disclosures of Protected Health Information Based Upon your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's office has taken an action in reliance on the use or disclosure indicated in the authorization.

Other permitted and Required Uses and Disclosures That May Be Made with your Consent, Authorization, or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present to able to agree to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your nest interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others involved in your healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable or unavailable 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your physician or anther physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication barriers: We may use of disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures That May be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: As required by law, we may use or disclose your protected health information. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required bylaw, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities to a public health authority that is required by law to collect or receive the information. The disclosure will me made for the purpose of controlling disease, injury, or disability. We may also disclose

your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable disease: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or neglect: Your protected health information may be disclosed if your physician or another physician believes that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and drug administration: We may disclose your health information to a person or company required by the Food and Drug Administration to report reactions to medications or problems with products.

Legal proceedings: Your protected health information may be disclosed in the course of any judicial proceeding, in response to an order of a court. In certain conditions as to a response to a subpoena, legal request, or other lawful process.

Law enforcement: We may also disclose protected health information to a law enforcement official for purposes such as identification of locating a suspect, fugitive, material witness, or missing person. Also, we will disclose protected health information to identify or apprehend and individual.

Deceased person information and organ donation: We may disclose your protected health information to a coroner, funeral director, or medical examiner for identification purposes, determining cause of death or assisting in their performing of duties. Protected health information may be disclosed to organizations involved in procuring, banking, or transplanting organs and tissues.

Research: Your protected health information may be disclosed to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Public safety: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Military activity and National security: When the appropriate conditions apply, we may use and disclose protected health information of individuals who are Armed Forces personnel for activities necessary by military command authorities. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

Worker's compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care for you.

II. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means that you may inspect and obtain a copy of protected health information about you that is contained in a designated record for as long as we maintain the protected health information. This designated record contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. You must submit a request in writing to the HIPAA officer. The patient may be charged with the cost of copying and mailing, or other supplies associated with the request.

La. R.S. 40:1299.96 sets forth the rules under which Louisiana health care providers can typically charge for record requests. The reasonable fees include: 1) a reasonable copying charge, not to exceed one dollar per page for the first twenty-five, fifty cents per page for twenty-six to five hundred pages, and twenty-five cents per page thereafter. 2) actual postage cost, and 3) preparation and handling cost not to exceed fifteen dollars for hospitals and seven dollars and fifty cents for other health care providers.

Under federal law, however you may not inspect or copy the following records: psychotherapy notes, information for use in a civil or criminal proceeding, or information that is subject to law and prohibits access. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our HIPAA officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This allows you to ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Policy. Your request must state the specific restriction requested and to whom you want the restriction to

apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If you physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting the request in writing and forwarded to the HIPAA officer.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests, and we may ask you for information as to how payment will be handled or specification of an alternative address other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request. Please make this request in writing to our HIPAA officer.

You may have the right to have your physician amend your protected health information. This means that you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of such a rebuttal. Please contact our HIPAA officer to determine if you have questions about amending your medical record.

You have the right to receive an account of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Policy. It excludes disclosures we may have made to you, to family members involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Your have the right to obtain a paper copy of this notice from us. Upon request, you may receive a paper copy of this Notice of Privacy Policy even if you have agreed to accept this notice electronically.

III. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us be notifying our HIPAA officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our HIPAA officer, at (337) 993-3933 for further information about the complaint process.

Updates to HIPAA Privacy and Security Rule—Omnibus Rule

I. Marketing

All psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute the sale of PHI requires authorization.

II. Fundraising

An individual has the right to opt out of such fundraising communications in the event that the provider is engaged in fundraising activities.

III. Restricted Disclosures

An individual has the right to restrict certain disclosures of PHI to a health plan where the individual or someone on his or her behalf pays out of pocket for the health care item or service.

IV. Breach Notification

An individual has the right to be notified following a breach of their PHI. The covered entity is only required to disclose a simple statement of breach notification and is not required to disclose how the breach occurred and entity will evaluate whether PHI has been comprised under the Breach Notification Rule, or include a description of the regulatory requirements.

V. Other uses and disclosures

All other uses and disclosures not described in the covered entity's Notice of Privacy Practice will be made only with the authorization of the individual.

LAFAYETTE OBGYN

Mary L. Laville, M.D.

HIPAA

Authorization for Individuals Involved in the Care of a Patient

I give Lafayette OBGYN permission to release medical information to the following individuals:

Name:_____Relationship to patient:_____Tel#_____

Name:_____Relationship to patient:_____Tel#_____

Name:_____Relationship to patient:_____Tel#_____

Authorization to Leave Detailed Message

I hereby authorize my provider or other representative of Lafayette OBGYN to leave a detailed message concerning my lab results, insurance/billing information or questions, appointments, surgery, prescriptions, or any other issues on the following devices:

Please check all that apply and write the appropriate phone number in the blank:

____Answering machine at home:_____
____Voicemail at work:_____
____Cell phone:_____
____Other:_____

RECEIPT OF LAFAYETTE OBGYN POLICIES

By signing below, I agree that I have received and read the documents listed below. I had the opportunity to ask questions and all were answered to my satisfaction. The above authorizations are valid until such time as I revoke them in writing.

1. **OFFICE/ FINANCIAL POLICY AGREEMENT**
2. **ELECTRONIC PAYMENT AUTHORIZATION**
3. **NOTICE OF PRIVACY POLICY**

Patient Name:_____DOB:_____

Signature:_____Date:_____

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