

PATIENT INFORMATION

Name you preferred to be called _____ (Married, Single, Widowed, Divorced) circle one

Today's Date _____ NAME _____ Age _____

Occupation _____ Employer _____ Phone _____

Date of Birth _____ SS# _____ Home Phone _____

Address: Street _____ Town _____ Zip Code _____

Cell phone _____ Email _____

Spouse/Parent Name _____ Day Phone _____ Evening _____

Spouse Employer _____ Phone _____

Emergency Contact (Other than spouse) Name _____ Day Phone _____ Evening _____

Alternate Contact Name _____ Day Phone _____ Evening _____

Family Doctor Name _____ Phone _____

Pharmacy Name _____ Phone _____

Primary Insurance _____ Policy # _____ Group # _____

Subscriber _____ D.O.B. _____ SS# _____

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber _____ D.O.B. _____ SS# _____

<p>Allergies to Medications? _____</p> <p>_____</p> <p>_____</p> <p>Medications currently taking: _____</p> <p>_____</p> <p>_____</p> <p>First Day of your last period? _____</p> <p>How many days from the start of one period to the start of the next _____</p> <p>Any spotting or bleeding between periods? YES or NO</p> <p>How long do you bleed with your periods? _____</p> <p>What form of birth control do you use? _____</p> <p>Are you satisfied with this method? YES or NO</p> <p>Do you have any history of abnormal pap's? YES or NO</p> <p>Do you have any history of STD (Chlamydia, gonorrhea, herpes, warts)? YES or NO</p> <p>Have you had a new sexual partner since your last visit? YES or NO</p> <p>Do you desire STD testing today? YES or NO</p> <p>Do you smoke? YES or NO # daily _____ # of years _____</p> <p>Do you drink alcohol? YES or NO # daily _____ # weekly _____</p>	<p>Do you use caffeine (chocolate, cola, coffee, tea)? YES or NO # daily _____</p> <p>Do you check your breasts monthly? YES or NO</p> <p>ANCESTRY:</p> <p><input type="checkbox"/> Western/Northern Europe <input type="checkbox"/> Ashkenazi</p> <p><input type="checkbox"/> Central/Eastern Europe <input type="checkbox"/> Latin American/Caribbean</p> <p><input type="checkbox"/> Africa <input type="checkbox"/> Asia</p> <p><input type="checkbox"/> Neareast/Mideast <input type="checkbox"/> Native American</p> <p><input type="checkbox"/> Other _____</p> <p>Do you have any current breast problems? _____</p> <p>_____</p> <p>What ongoing medical problems do you have? _____</p> <p>_____</p> <p>What illness or surgery have you had since your last visit here? _____</p> <p>Has there been any breast, ovarian, endometrial, cervical or colon cancer detected in your family? YES or NO</p> <p>Who? _____</p> <p>Do you have any concerns for the Doctor today? YES or NO</p> <p>If yes what concerns? _____</p> <p>_____</p>
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I hereby authorize the release of any information relating to all claims for benefits submitted on my behalf. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize all payments to go directly to my physician. I understand that I am financially responsible for all charges whether or not paid by insurance. Should my account be forwarded to a collection service, I agree to be responsible for any and all fees which may be charged by the collection service company.

SIGNATURE _____ DATE _____

Please read and sign below:

I authorize Women’s Health Consultants to release to my insurance carriers, the Social Security Administration and **Healthcare Financing Administration**, or its intermediaries to carriers, any information needed for processing this insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to **Women’s Health Consultants**.

Signature: _____ Date: _____

MEDICARE RECIPIENT:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Women’s Health Consultants for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

AUTHORIZATION TO DISCUSS MEDICAL RECORD WITH THIRD PARTY

First and foremost, a patient has a right to confidentiality in her medical records. Healthcare providers are required by law to maintain confidentiality and refrain from making unauthorized disclosures of patient's medical information. Therefore, if for any reason you would like to give this office permission to discuss your medical record with anyone other than yourself, please indicate below the name or names of the individual(s) and his or her relationship to you:

For the purpose of continuity of care, I hereby authorize Women’s Health Consultants to release all pertinent information regarding my care and treatment to the following individual(s) who are acting on my behalf and at my request:

 Name of Authorized Representative

 Relationship to Patient

 Name of Authorized Representative

 Relationship to Patient

Patient’s Signature

Today’s Date

1611 Pond Road, Suite 101, Allentown, PA 18104
Telephone: (610) 841-8020 Fax: (610) 366-8550

Carolyn S. Scott, MD, FACOG
Deborah L. Villeneuve, MD, FACOG
Gaylynn M. Faust-Rakos, DO, FACOOG
Zirka M. Halibev, MD, FACOG

In order to comply with specific rules regarding HIPPA (Health Insurance Portability and Accountability Act of 1996) we ask that our patients review and sign a privacy and security of health information document.

It is the office policy of the Women's Health Consultants and staff to not release confidential and/or unauthorized information by home phone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name and telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Women's Health Consultants and staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

(Please circle one)

HOME TELEPHONE ()	YES	NO	N/A
ANSWERING MACHINE	YES	NO	N/A
WORK TELEPHONE ()	YES	NO	N/A
VOICEMAIL	YES	NO	N/A
CELL PHONE ()	YES	NO	N/A
VOICEMAIL/CELL ()	YES	NO	N/A
PAGER ()	YES	NO	N/A
EMAIL	YES	NO	N/A

EMAIL ADDRESS _____

Release any Medical records/films to another facility or medical office. (Per patient request).
YES NO N/A

Will you allow the Women's Health Consultants to leave a message regarding an appointment confirmation?
HOME WORK NONE

Please list name of any individuals you prefer us to leave information with:

Patient/Guardian: _____ **Date:** _____

FINANCIAL POLICY

PA BLUE SHIELD, CAPITAL BLUE CROSS

We are participating providers with PA Blue Shield and Capital Blue Cross. *Most plans will not pay for your office visits. Therefore, payment is due at the time service is rendered.* Insurance plans that cover office visits must be identified by you that your coverage is comprehensive. You remain responsible for co-payments and deductibles. Due to our participating status, we are not allowed to file with your Major Medical. This is the patient's responsibility.

MEDICARE:

We are participating providers with Medicare. This means we will receive 80% of the approved amount from Medicare, *but you remain responsible for the 20% balance and any deductible amount.* Please inform us if you have a co-insurance (a secondary insurance company) to handle this 20% portion.

HMO's: KEYSTONE HEALTH PLAN, US HEALTHCARE, PROCARE, ETC.:

The patient is required to provide this office with a referral slip from your primary physician. *Make sure to call your primary care physician's ("PCP") office to obtain the referral before coming to your appointment at /his office.* Patients without the proper referral slip will be rescheduled for another appointment time. No exceptions.

Also, some HMO's (US Healthcare, for example) require that we use a specific lab for any tests done at this office, and they will not pay for any lab work performed at any other lab. This office uses Quest Laboratories for all of its lab work, unless we are informed by you that your insurance plan requires another lab. *It is the patient's responsibility to inform this office of any specific lab requirements under their insurance plan. If we are not advised, and your insurance plan refuses to reimburse us for lab work sent to our preferred lab, the patient will be required to pay this cost directly to our office.*

MANAGED CARE PLANS: COMMUNITY CHOICE, POINT OF SERVICE, ETC.:

The patient is required to understand their insurance and reimbursement for services provided by a specialist physician. Some managed care plans require your signature on a self-referral form when a referral slip was not obtained. If you refuse to sign the self-referral to specialist form, your appointment will be rescheduled for another time in order to meet your insurance stipulations.

Also, some Managed Care Plans require that we use a specific lab for any tests done at this office, and they will not pay for any lab work performed at any other lab. This office uses Quest Laboratories for all of its lab work, unless we are informed by you that your insurance plan requires another lab. *It is the patient's responsibility to inform this office of any specific lab requirements under their insurance plan. If we are not so advised, and your insurance plan refuses to pay the lab fee, the patient will be required to pay this cost directly to the lab.*

COMMERCIAL INSURANCE:

We have participating contracts with the following:

- 1) HealthEast Spectrum Administrators;
- 2) Kovatch/Spectrum Administrators
- 3) Prunetwork;
- 4) Corporate Health Administrators;
- 5) Corporate Health Insurance.

If you have any commercial insurance carrier than stated above, you will be responsible for payment in full on all office visits. A paid receipt will be provided to you to forward to your carrier for reimbursement. Should you need surgery, we will bill to your insurance company, and look for payment from the carrier. Any coinsurances and/or deductibles will be billed to the patient.

PRE-CERTIFICATION:

Many insurance companies require pre-certification and/or a second opinion. It is the patient's responsibility to inform our office about any pre-certification and/or second opinion your insurance plan requires. *Failure to adhere to these requirements may result in your having to pay 50% to 80% of your claim.*

- Our practice is committed to providing the best medical treatment available for our patients, and we charge a usual and customary fee for our area. You may be responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.
- Accounts not paid within an acceptable time frame are forwarded to our collection agency. All accounts forwarded due to non-compliance for payments are also reported to your local credit bureau.
- Our business staff is available to answer any questions you may have regarding your balance with us. Please do not hesitate to call during our normal business hours: 8:30 a.m. to 5:00 p.m., Monday through Friday.

PATIENTS WITHOUT INSURANCE COVERAGE:

Our policy does not include becoming involved in litigation, under any circumstances. Payment is expected at the time service is rendered, unless outlined above. We accept CASH, CHECKS, VISA, MASTERCARD and DISCOVER.

I have read and understood the above Women's Health Consultants Financial Policy.

ALL PATIENTS (or responsible party) MUST SIGN THIS FORM

Patient or Responsible Party Signature

Date



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge having received a copy of the Women's Health Consultants' Notice of Privacy Practices.

Signature

Date

Print your name

CAROLYN S. SCOTT, MD
FACOG

DEBORAH L. VILLENEUVE, MD
FACOG

GAYLLYN M. FAUST-RAKOS, DO
FACOG

ZIRKA M. HALIBEY, MD
FACOG

PARAGON CENTRE
1611 POND ROAD
SUITE 101
ALLENTOWN, PA 18104

PHONE: (610) 841-8020

FAX: (610) 366-8550

BETHLEHEM MEDICAL ARTS BUILDING
5325 Northgate Drive
SUITE 202
BETHLEHEM, PA 18017

www.whc-info.com

RIGHTS OF PATIENTS

- The patient has the right to considerate and respectful care in a safe environment.
- The patient has the right to obtain from her physician complete, current information concerning her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
- The patient has the right to receive from her physician information necessary to give informed consent prior to the start of any procedure and/or treatment.
- The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of her action.
- The patient has the right to every consideration of privacy concerning her own medical care program.
- The patient has the right to expect that all communications and records pertaining to her care should be treated as confidential.
- The patient has the right to an assessment of their pain and the provision of appropriate care, treatment or referral to other resources for management of their pain.
- The patient has the right to expect that within its capacity, Women's Health Consultants must make reasonable response to the request of a patient. .
- The patient has the right to obtain information as to any relationship of WHC to other health care and educational institutions insofar as her care is concerned.
- The patient has the right to be advised if WHC proposes to engage in or perform human experimentation effecting her care or treatment.
- The patient has the right to expect reasonable continuity of care.
- The patient has the right to examine and receive an explanation of her bill regardless of source of payment.
- The patient has the right to know what WHC rules and regulations apply to her conduct as a patient.

PATIENT RESPONSIBILITIES

- The patient has the responsibility of keeping her appointment, be on time and when unable to do so, to cancel and reschedule.
- The patient has the responsibility of being considerate of other patients and staff.
- The patient has the responsibility of reporting any pain or discomfort they may have.
- The patient has the responsibility of informing the provider about her advanced directive if she has one.
- The patient has the responsibility of letting your provider know when you do not understand what is being said to you regarding your treatment and diagnosis.
- The patient has the responsibility of reporting any changes in address, telephone number, financial and/or insurance status.
- The patient is responsible for assuring that her provider has the most accurate and complete information possible regarding your physical and mental health concerns, past illnesses, hospitalizations, current and past medications and unexpected changes in your overall health.
- The patient has the responsibility for being honest with us, for doing what you and your provider have agreed upon. You must understand that if you do not do so, then you will be responsible for the outcome.
- The patient is responsible for informing your provider of any cultural, religious, personal and ethnic considerations regarding your care.
- The patient is responsible for providing us with accurate information regarding your health insurance plan, obtaining any/all necessary referrals according to your health insurance plan policy and for prompt payment of services not covered by health insurance.

ITEMS NEEDED FOR APPOINTMENT

Please remember to bring the following items with you on the day of your appointment:

1. The papers we included with the packet
(Please complete them prior to your appointment)
2. Insurance card or cards
3. Driver's License/Photo ID
4. Your referral if you are a Managed or HMO patient (unless referrals are done electronically by your provider)
5. Name, Dosage, & Strength of **ALL** Medications, Vitamins, and Herbal Supplements you are currently taking.
6. List of any known allergies
7. List of **ALL** prior surgeries. Please include reason for surgery and date of surgery.
8. List of **ALL** Doctors you currently see (Please include addresses and phone numbers if possible)

Please arrive 15 minutes prior to your scheduled appointment time.

If you have any questions regarding the information listed above, please feel free to contact us at 610-841-8020.

CAROLYN S. SCOTT, MD
FACOG

DEBORAH L. VILLENEUVE, MD
FACOG

GAYLLYN M. FAUST-RAKOS, DO
FACOG

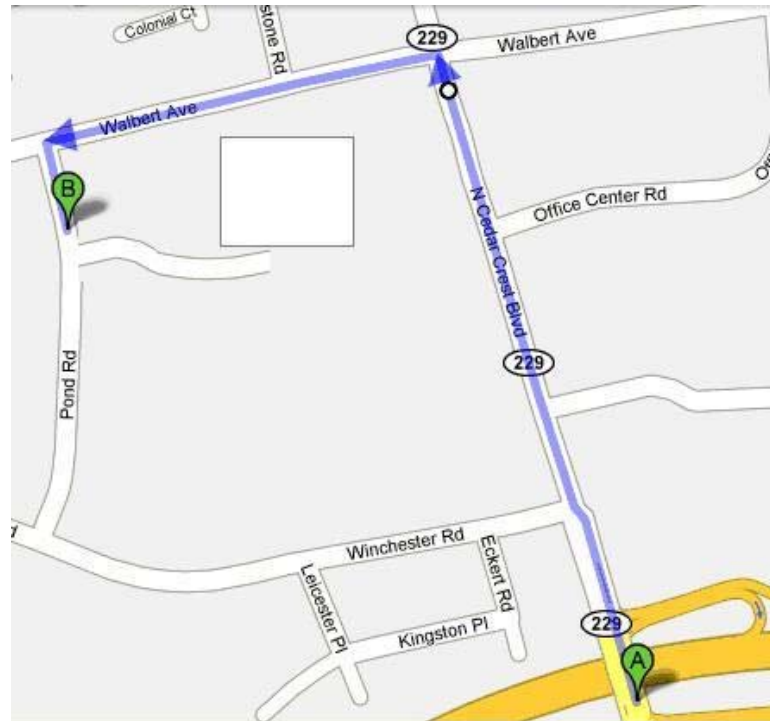
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Directions to Our Allentown Office



Allentown Office (Paragon Center)
1611 Pond Road Suite 101
Allentown, PA 18104

Driving Directions:

Route 22 to Allentown to Cedar Crest Blvd. Exit (North). Whether coming from the east or west, make a right at end of exit ramp. After passing Crest Plaza Shopping Center on your left, make LEFT at first traffic light (intersection with Walbert Avenue). Make first LEFT onto POND ROAD. 1611 POND ROAD (The Paragon Center) is first building on left. PLEASE PARK IN BACK FOR MAIN ENTRANCE.

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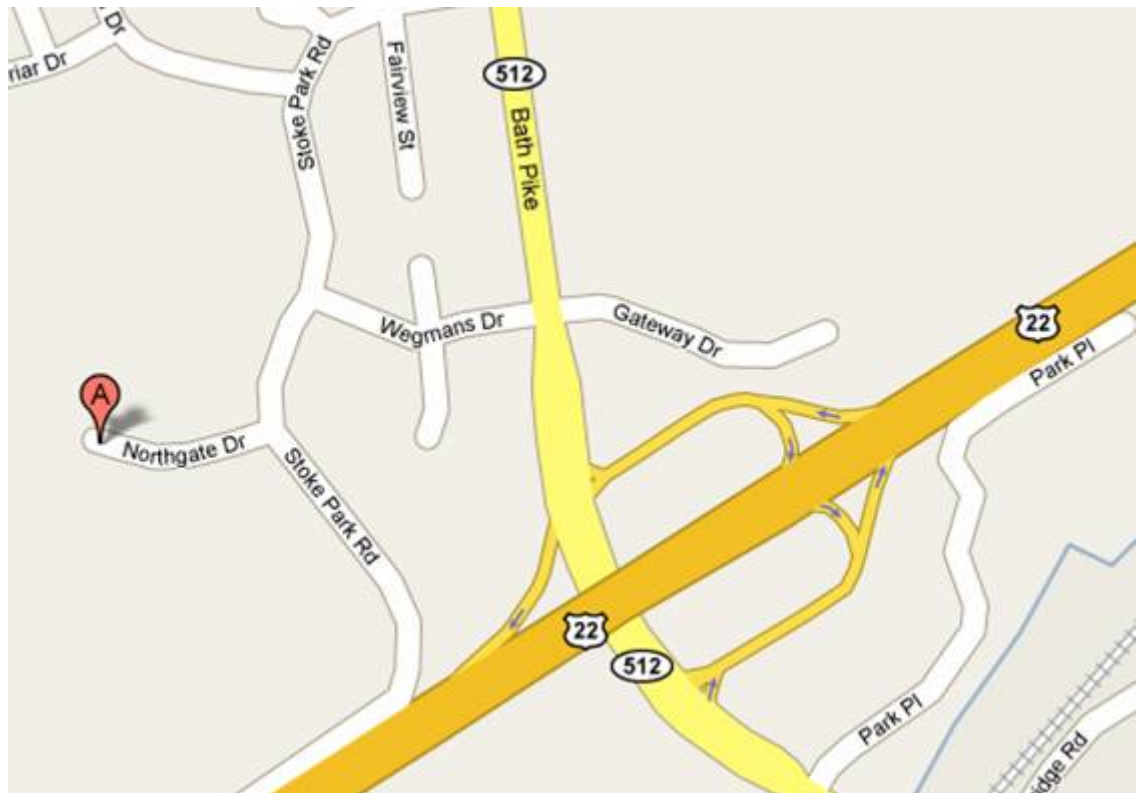
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5325 Northgate Drive
SUITE 202
BETHLEHEM, PA 18017

www.whc-info.com

Directions to Our Bethlehem Office



Bethlehem Office (Bethlehem Medical Arts Building)
5325 Northgate Drive. Suite 202
Bethlehem, PA 18017

Driving Directions:

From Route 22 (east or west), take the Route 512 exit. Make a RIGHT at the end of the ramp onto 512 north. At the 3rd light, make a LEFT onto Stoke Park Road (toward Wegman's). Pass Wegman's on your right. Make a RIGHT, after passing Wegman's, onto Northgate Drive. Northgate Drive enters the parking lot of the Bethlehem Medical Arts Building.

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.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Women's Health Consultants is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the waiting area or at our website at www.lvwcc.com. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the waiting area or at our website at www.lvwcc.com. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as

to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. 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 by telephone or reminder card.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing and collections, accreditation, software support and quality assurance. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical 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.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

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

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of the Women's Health Consultants that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited

circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to Women's Health Consultants in writing. The practice may charge for copies of the medical record in accordance with Pennsylvania state law

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Women's Health Consultants will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be \$10.00. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

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. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

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.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (610) 841-8020 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Office Manager
Telephone Number: (610) 841-8020



Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

**1611 Pond Road, Suite 101
Allentown, PA 18104
Tele: (610) 841-8020
Fax: (610) 366-8550**

**Effective:
April 14, 2003**

Prepared by Total Compliance Solutions, Inc. These procedures are prepared with the understanding that Total Compliance Solutions and its agents are not engaged in rendering legal, accounting, or other professional services. This information is advisory only. Final interpretation is the responsibility of the regulatory or accrediting body administering the standard or regulation referenced.