

This notice applies to all records generated by your physician, office medical or billing personnel, or Business Associates.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information and provide a description of our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction.

USE AND RELEASE OF MEDICAL INFORMATION

We may use and release your medical information (clinical and billing) for:

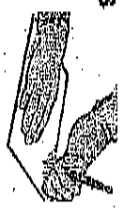
- Payment, Treatment, Healthcare Operations
- Business Associates
- Appointment Reminders
- Treatment Alternative Education
- Health-related Benefits or Services
- As required by law to State/Federal Agencies
- Family or friends involved in your care
- Entities assisting in Disaster Relief

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare provider, you have the Right to:

- Access Information
- Request Amendments
- An Accounting of Disclosures
- Request Privacy Restrictions
- Request Alternate Communication
- File Complaints
- Obtain a Detailed Copy of this Notice

Please refer all requests to our Privacy Official:



Access:

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but there are limited circumstances in which we can deny your request. These denials must be provided to you in writing, and you may request a second review in writing.

Amend:

If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend, or add to the information. You have the right to request an amendment for as long as the information is kept by or for the physician.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial in writing.

AN ACCOUNTING OF DISCLOSURES:

You have the right to request an accounting of disclosures of medical information about you. This does not include disclosures for treatment, payment, operations, or to you or your authorized representative.

Request Restrictions:

You have the right to request a restriction or limitation on the medical information we use or release about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we release about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, but will do so if the request is reasonable.

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. We reserve the right to contact you by other means and at other locations if you fail to respond to communications from us.



A PAPER COPY OF THIS NOTICE:

You have the right to a detailed 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.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Official or with the Secretary of the Department of Health and Human Services. All complaints must be 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 release medical information about you, you may withdraw that permission, in writing, at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the practice and include the effective date. We can provide additional copies of the notice when you check in for future appointments, at your request.

If you have any questions about this notice, would like to request a form or have any complaints, please contact:

Privacy Official:

Nancy Rohr

Phone Number:

303.584.8221

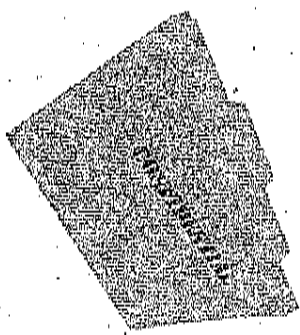


Prepared by HCA Management Services, LP

Minimally Invasive Gynecology
Center of Denver

**NOTICE OF
PRIVACY PRACTICES**

Effective Date: April 14, 2003



This notice describes how medical information about you may be used and released and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

HealthONE Clinic Services

Practice Name

Mountain Vista Women's Care

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Mountain Vista Women's Care may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Mountain Vista Women's Care will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Mountain Vista Women's Care

I acknowledge that I have been given the Notice of Privacy Practices by Mountain Vista Women's Care

I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

*Patient (or Responsible Party) Signature*_____
Date

Original - Practice

HIM.PRI.001, HIM.PRI.007

Revision Date: May 22, 2003

OB QUESTIONNAIRE

- | | | | |
|-----|--|---|--|
| 1. | Will you be age 35 or older when the baby is due? | Yes | No |
| 2. | Have you or the baby's father or anyone in either of your families ever had
*Down Syndrome or Mongolism
*Spina Bifida or Meningomyelocele (open spine)
*Hemophilia
*Muscular Dystrophy
*Thalassemia
*Cystic Fibrosis
*Huntington's Chorea | Yes
Yes
Yes
Yes
Yes
Yes
Yes | No
No
No
No
No
No
No |
| 3. | Have you or the baby's father had a child born dead or Alive with a birth defect not listed in question #2? | Yes | No |
| 4. | Do you or the baby's father have any close relatives who are mentally retarded or have mental illness?
If yes please explain _____ | Yes | No |
| 5. | Do you or the baby's father, or close relatives in either of your families have any inherited genetic or chromosomal Disease or disorder not listed. | Yes | No |
| 6. | Have you, or the spouse of this baby's father in a previous Marriage, had three or more spontaneous pregnancy losses? | Yes | No |
| 7. | Do you or the baby's father have any close relatives Decended from Jewish people who lived in Eastern Europe (Ashkenazic Jews)? | Yes | No |
| 8. | If you or father of baby are African American, have either of you or any close relatives been screened for sickle Cell trait, and found to be positive?
If yes please explain _____ | Yes | No |
| 9. | Do you have a cat? | Yes | No |
| 10. | Have you or the father of the baby ever had herpes? | Yes | No |
| 11. | Have you or the baby's father ever been exposed to Dangerous drugs, chemicals, radiation or infections? | Yes | No |

I have discussed with my doctor the above questions which are answered "yes" and understand that I am at an increased risk for _____ and it may be possible to diagnose an affected fetus by further testing.

Signature: _____

Date _____

Pregnancy and Medication Risks

Many medications which are used routinely in women of child bearing age may not be safe during pregnancy. While such medications are not known to harm the developing fetus or to interfere with the pregnancy, many are just not adequately tested to assure safety.

Any delay in recognition of pregnancy may allow use of medications which may be reconsidered if pregnancy were known. Any patient who may be pregnant or who is attempting to become pregnant (or any patient who is having sexual contact without certain protection) should inform her physician before taking any prescription medication.

If you are on any medication (including over-the-counter medications) and may become pregnant during treatment, you should discuss that with your physician.

If you have any questions about this information, discuss them with your physician.

Sign below indicating that you have received and understood this information and had an opportunity to have your questions answered. You may have an extra copy of this form to take home with you for your information and to discuss with your spouse or family.

DATE

PATIENT SIGNATURE

PRINT NAME

1/91 REV.

**MOUNTAIN VISTA WOMEN'S CARE
 DRS. VIRGINIA ALLISON, SUSAN BRASHEAR, KEN MOSS, ANDREW ROSS
 JOAN GIRARD, N.P. & SHELBIE LOPEZ W.H.C.M.P**

CONSENT - HIV TESTING

I _____ hereby authorize Drs. Virginia Allison, Susan Brashear, Andrew Ross, Ken Moss, nurses Joan Girard and Shelbie Lopez to order the performance of blood tests to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), or of HIV antigens in my blood. I understand that infection with HIV may produce no symptoms, may be associated with mild illness or may sometimes progress to acquires Immunodeficiency Syndrome (AIDS).

RESULTS:

I have discussed with my provider the reason for performance of these tests. I understand that false-positive and false-negative test results can occur. That is, a positive test result may not necessarily accurately predict the presence of HIV infection, and conversely, that HIV infection can still be present even if some or all test results are negative.

RECORDING OF RESULTS:

I understand that the results of these tests. Whether positive or negative, will become a permanent part of my hospital or outpatient medical record. I understand that information in my medical record can be obtained by my health insurance carrier, if I have one, by a person or entity to whom I give written permission for access to my medial record, and under certain circumstances, by subpoena or by court order. Positive test results will be reported to State Regulatory agencies as may be required by law.

INFORMED CONSENT:

I certify that I have read and fully understood the above informed consent statement, which has been preceded by an explanation by my doctor, and was understood by me. By my signature below, I acknowledge and understand the above information and give my informed consent.

Signature: _____ Date _____

Witness: _____ Date _____