Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

- We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it.
- We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.
- You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot obtain, use or disclose your health information for any reason except for obtaining, using, or disclosing information from or to other providers, radiology facilities and hospitals to aid in your treatment.
Security: You will be notified as soon as possible if the security of your personal health information is breached.

Uses and Disclosures of Health Information:

We may use and disclose your health information without authorization for the following purposes.
Treatment: We may use or disclose your health information for your treatment. For example, we may use and disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interest that may be involved with your treatment.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Decedents: We may disclose health information about a decedent as authorized or required by law.
Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody the protected health information of an inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails or letters).
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or healthcare operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.
It is important for you to understand email is not a secure form of communication and content communicated in emails may be intercepted by unauthorized third parties (e.g. computer hackers). Additionally, emails can accidentally be sent to individuals or groups for whom the email was not intended. It is important for you to understand these risks if you choose to communicate with Alaska Center for Pain Relief via email.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Non-disclosure to the insurance company: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.
Electronic Notice: You may receive a paper copy of this notice upon request.

Questions and Complaints

- If you want more information about our privacy practices or have questions or concerns, please contact us.
- If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care and will be pleased to discuss our fees. Your clear understanding of our Financial Policy is important to our professional relationship. All patients must review and sign this form before seeing the doctor for the first time. Please ask if you have any questions about fees, our Financial Policy, or your responsibility.

Our practice is In-Network with most major insurance companies. (BCBS, Cigna, United Health, Multiplan, Aetna, Tricare, and Medicare) All patients must complete their patient registration form and give us the necessary information before seeing a provider. **You are responsible for any portion of your bill that your insurance carrier denies or does not cover**. If your deductible is not met, we will require payment in full at the time of service. Any co-payment will be collected during service if your deductible has been met. We accept personal checks, Mastercard, Visa, and Debit cards.

The balance will become your responsibility if your insurance has not fully paid your account within 45 days. If we do not receive your payment in full within 90 days from the date of the first statement, your account may be turned over to a third-party collection agency. *Your Insurance coverage is a contract between you and your insurance carrier*; however, we are available to assist you in maximizing your insurance benefits.

Please be aware that few insurance companies attempt to cover all medical costs. Some pay fixed allowances for each procedure, while others pay only a percentage of the cost. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If your carrier requires a pre-authorization before certain procedures, our office will assist in obtaining it before your treatment. Preauthorization is not a guarantee of payment.

Aetna Supplemental Contraceptive PPO plans: If you are using a supplemental contraceptive plan, please be aware that these plans often do not cover contraceptive devices or procedures, including IUD placement or replacement. You may be financially responsible for these services.

Please keep in mind if routine lab tests are required, as a courtesy, we will collect the specimen(s) to be sent out to Lab Corp while you are in the office if time permits. However, please remember that you will receive a separate bill from Lab Corp.

Please be advised that Modern Gynecology and Skin is a sister company of Alaska Center for Pain Relief, for which your billing statements will reflect.

Patients without insurance
Patients being seen for medical reasons which do not have health insurance will be expected to pay for their first consultation in full at the time of service. If further testing or procedures are necessary, each case will be addressed individually at the time to work out a payment plan.

Charges may also be made for no-show appointments and appointments canceled without 24 hours of advance notice. N0-shows and repeated cancellations may limit your ability to make future appointments.

If you have any questions concerning our Financial Policy; or if this creates an undue hardship, please contact our practice immediately to discuss special arrangements. You may reach our Office Manager through our main number (907-339-0363)

- By signing below, I verify that I have read and understand this Financial Policy:
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Modern Gynecology to release pertinent information to my insurance company when requested in order to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Modern Gynecology.
- I understand that the balance may be referred to a collection agency if this debt becomes delinquent by 90 days after the first statement is sent out. I will be held responsible for all fees associated with collecting my debt.

AUTHORIZATION FOR THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR PATIENTS

I hereby authorize and direct my insurance benefits to be paid directly to my personal physician or Modern Gynecology.

I also authorize Modern Gynecology to release any information necessary to process this claim. I understand that information will be released to:

- The billing department of the physician and/or practice
- Insurance carrier to process the claim

I understand that my information, under certain circumstances, may be released for one of the following reasons:

- Other Healthcare professionals to coordinate my care or treatment
- Insurance adjuster - if my claim is a work or motor vehicle injury
- Employer - if my claim is related to a work injury
- Attorney - if my claim is in a litigation process
- Health insurance carrier, for chart audit reasons, and for claim payment

I understand that Modern Gynecology and/or their staff and billing office will not release any information to me or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that Modern Gynecology and/or their staff and billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request, to your insurer, employer, family member or otherwise.

With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, their staff, and/ or their billing office control.

Explanation of Fees for Gynecological Visits

We are required by our contract with your chosen insurance carrier to file your claims according to the services that we provide. There are two basic types of visits:

1) **Routine, Well-woman, Preventative, or Yearly Visit:** These are visits to prevent health problems and to review any recommended age-appropriate screening tests such as mammograms, pap smears, and bone density analysis. Weight, smoking, diet, constipation, vaccinations, sterilization, contraception, STD screenings, and lipid screening might be addressed. This is not a visit to discuss current problems that you might be having that need to be addressed or to prescribe new medications. Current prescriptions may be refilled if there are no changes to your health since you were last seen. Insurance only covers these types of visits once a year. If your claim is denied for this reason, we will bill you for this visit as non-covered.

2) **Problem/Follow-Up Visits:** These are visits to address symptoms or complaints that might signify the need for diagnosis and treatment or require the ordering of further testing for evaluation. They may be for illness or follow-up of a medical condition. These types of visits may be for menopause symptoms, period problems, infertility, headaches, insomnia, sexual dysfunction, fatigue, depression, pain, etc. These visits will focus on the problems that you want to discuss. The visit may or may not include an examination.

Your coverage for these two types of office visits is determined by your particular insurance contract. It is your responsibility to know what is covered at 100%, what is covered with a deductible and/or a copayment, and what services are not covered.

If you want to have your visit limited to a Preventative/Annual Visit it is your responsibility to make that known before seeing Dr. Jill. If your visit expands to a Problem Visit as described above, the visit will be billed accordingly and additional deductibles and copayments will be applied.

We will make every effort to help you maximize your insurance coverage but we will bill according to national billing guidelines. We will not be able to honor requests to change what was billed at any time unless there was a billing/coding error.

At either type of visit, laboratory testing may be ordered. We will code the reason for the testing appropriately but the laboratory is responsible for billing your insurance. For lab work, you may still be responsible for deductible and copayment even if the visit is covered at 100%. It is important to know what lab is preferred for your insurance and to let the office staff know at the time of your visit. All labs drawn in the office are sent to and billed by Labcorp.

PATIENT PORTAL MESSAGING & BILLING NOTICE

Certain patient-initiated messages sent through the patient portal may be **billable** if they require medical assessment and decision-making by a provider.

A message may be billed to your insurance if it meets **all** of the following criteria:

- **Patient-initiated:** The message is sent by you seeking medical guidance.
- **Clinical decision-making:** Your provider must review your concern and make a medical decision (e.g., adjusting medication, ordering tests, evaluating new or changing symptoms).
- **Time requirement:** The provider spends **at least 5 minutes** reviewing your chart, researching, and preparing a clinical response.

By using the patient portal, you acknowledge that messages requiring medical assessment may be billed to your insurance. If a potential charge applies, your provider will determine this based on the nature and complexity of the message.

INFORMED CONSENT FOR TELEHEALTH SERVICES

I understand that telehealth medicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Dr. Jillian Woodruff & associates providing health care services to me via telemedicine.

I understand that I have to be **currently located** in the state of Alaska to have a Telehealth visit conducted.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth medicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurance that apply to my telehealth medicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telehealth medicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Modern Gynecology at 907-339-0363. As long as this consent is in force (has not been revoked) Dr. Jillian Woodruff may provide health care services to me via telemedicine without the need for me to sign another consent form.

USE OF STANDARDIZED HEALTH SCREENING QUESTIONNAIRES

As part of your ongoing care, Modern Gynecology may ask you to complete standardized, evidence-based health screening questionnaires, including but not limited to the **Female: PHQ-9, GAD-7, and FSFI or Male: SHIM / IIEF-5, GAD-7, PHQ-9**. These tools are used to assess symptoms related to mood, anxiety, and sexual health, evaluate symptom severity, monitor changes over time, and support clinical decision-making. Your responses become part of your medical record and may be reviewed, scored, and interpreted by clinical staff and providers. Completion and clinical review of these questionnaires may be considered a billable medical service and may be submitted to your insurance carrier in accordance with national billing guidelines; coverage and patient financial responsibility are determined by your individual insurance plan, and you may be responsible for any charges not covered.

PHOTOGRAPHY AND VIDEO CONSENT

Surgical Documentation

I give Dr. Woodruff and her staff full consent to take photographs and/or videos of my surgical procedure, including during the Pre-Op, Intra-Op, and Post-Op periods. I understand these images are strictly for documentation and evaluation purposes related to my care. I also consent to having a photograph taken for identification purposes to be included in my medical chart. All photographs and videos will be securely stored in the electronic medical record system in full compliance with HIPAA regulations.

Educational And Marketing Uses

I understand that I have the **choice to either accept or decline** having my photographs and/or videos used for educational and marketing purposes. This may include use in various media outlets such as print, CD/DVD, or internet. All images will be used in an anonymous and confidential manner, with no identifying features or marks visible unless I provide explicit written approval.

Cancellation, No-Show & Appointment Policy

Pre-Appointment Requirements

If your provider has ordered labs or imaging (e.g., bloodwork, ultrasound) prior to your appointment, these must be completed in a timely manner so that results are received by our office before your scheduled visit.

Our clinical team reviews all upcoming appointments and will follow up with the lab or imaging center if results are not on file. However, it is the patient's responsibility to complete all ordered testing as soon as possible.

If required results are not available by the day of your appointment, the visit may be rescheduled, and a $150 late cancellation fee may apply.

Aesthetic Appointment Rescheduling (e.g., Botox, Microneedling)

Due to the limited availability and preparation involved in aesthetic services:

- Appointments rescheduled with less than **72 hours' (3 days)** notice will result in forfeiture of your deposit.
- A new deposit will be required to book any future aesthetic appointments.

General Cancellation & No-Show Policy

We understand that unexpected situations may arise. However, we kindly ask that you provide as much notice as possible when canceling or rescheduling an appointment. As a courtesy, an appointment reminder call to you is made/attempted 1 business day before your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

The following applies to all appointment types (excluding aesthetic and procedures, which follow separate policies):

- Cancellations with less than 24 hours' notice will incur a $150 late cancellation fee.
- Missed appointments without notice will be recorded as a "No-Show."
- A $150 No-Show fee will be charged for each missed appointment.
- If you have not arrived within **15 minutes** of your scheduled appointment time, your appointment may be marked as a No-Show and subject to the $150 fee.
- If you accumulate three (3) No-Show or late cancellation appointments within a 12-month period, dismissal from the practice may be considered. Written notification will be sent by mail if this occurs.

Procedure-Specific Cancellation Policy

For advanced in-office procedures that require special preparation or extended time (e.g., biopsies, NovaSure, labiaplasty, ThermiVa,):

- Cancellations with less than 24 hours' notice or failure to show will result in a $250 procedure no-show or late cancellation fee.

Patient Authorization for Use and Disclosure of Protected Health Information

(This form lets Modern Gynecology talk with a loved one, emergency contact, friend, or other person you choose about your care if needed- including if they call on your behalf or if there is an urgent or emergency situation and we cannot reach you directly.)

By signing this authorization, I _____ authorize Modern Gynecology to use and/or disclose certain Protected Health Information (PHI) about me to:

Name: _____

Relationship to Patient: _____ Phone: _____

Information to be Disclosed (check or describe):

- ☐ ALL relevant medical information
- ☐ Test results
- ☐ Treatment plans
- ☐ Billing/ insurance
- ☐ Other: _____

Authorization Applies To (check all that apply

- ☐ Routine care discussions
- ☐ Scheduling matters
- ☐ Test results/ treatment
- ☐ Billing questions
- ☐ Emergency situations when I cannot be reached
- ☐ When the individual calls on my behalf

Purpose and Scope of Disclosure:

This authorization allows Modern Gynecology to communicate with the individual listed above regarding my care, appointments, test results, billing matters, and treatment information. This includes situations where the listed individual contacts the practice on my behalf and urgent or emergency circumstances when I am unavailable or unable to communicate directly. By signing, I permit Modern Gynecology to speak with, share information with, and receive information from this individual regarding my medical care and related time-sensitive decisions.

Expiration: This authorization expires on _____ or upon this event: _____.

The Practice will not receive payment from a third party for using or disclosing this PHI. I am not required to sign this form to receive treatment. I may refuse to sign. Information disclosed under this authorization may be redisclosed and no longer protected by HIPAA. I may revoke this authorization in writing at any time except where action has already been taken in reliance on it. Revocation must be submitted to the Privacy Officer at 3851 Piper St – Suite U464, Anchorage, AK 99508.

Patient Name: _____

Signature: _____ **Date:** _____

If signed by legal representative, print name/relationship: _____

Signature: _____ **Date:** _____

Modern Gynecology Policies Agreement Form

(Signed Annually)

By initialing the following sections, I confirm that I have read, understood, and agree to the policies and procedures of Modern Gynecology.

_____ **Receipt of Notice of Privacy Practices Written Acknowledgment Form:** I acknowledge that I was provided a copy of the Notice of Privacy Practices for Modern Gynecology.

_____ **Financial Policy:** I verify that I have read and understand this Financial Policy.

_____ **Authorization for the Release of Information and Assignment of Benefits for Patients:** I have read, understood, and agreed to the Authorization and Release.

_____ **Explanation of Fees for Gynecological Visits:** I understand and agree to the terms of the Explanation of Fees.

_____ **Patient Portal Messaging & Billing Notice:** I understand and agree to the Patient Portal terms.

_____ **Informed Consent for Telehealth Services:** I understand and agree to the Telehealth terms.

_____ **Photography and Video Consent:** Strictly for documentation and evaluation purposes related to my care**.**

Photography and Video Consent- Educational and Marketing Uses:

_____ **AGREE** _____ **DECLINE**

_____ **No- Show/ Missed Appointment Policy:** I have read and understand the Modern Gynecology No Show/ Missed Appointment Policy and understand my responsibility to plan appointments accordingly. I agree to notify Modern Gynecology appropriately if I have difficulty keeping my scheduled appointments. Failure to do so may result in a $150 no show fee.

By initialing the above sections, I acknowledge that I have read, understood, and agree to abide by the policies and procedures in place for Modern Gynecology. I further consent to any treatments or services provided in accordance with these policies.

Patient Name: _____

Signature: _____ **Date:** _____

If signed by legal representative, print name/relationship: _____

Signature: _____ **Date:** _____