

BLOSSOM

GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

ANNUAL VISIT

Name: _____ Date: _____ DOB: _____

What brings you to the office today?

Last Menstrual Period: _____ How often: _____ Days of flow: _____ Amount of flow: _____
 Describe pain with period: _____

Using Contraception? No Yes What kind? _____ For how long? _____

List all Illnesses:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List all Surgeries:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Hospitalizations since last office visit: Yes _____ No _____

If Yes, please describe: _____

Allergies: None

1. _____
 2. _____
 3. _____
 4. _____

List all medications and dosages including over-the-counter:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Family History

Mother's Age:	Medical Issues:
Father's Age:	Medical Issues:
Brother's Age:	Medical Issues:
Brother's Age:	Medical Issues:
Sister's Age:	Medical Issues:
Sister's Age:	Medical Issues:
Additional information:	

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GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

ANNUAL VISIT – PAGE 2

Name: _____

Date: _____

Social History

<input type="checkbox"/> Non-Smoker	<input type="checkbox"/> Smoker – How many packs/day? _____
<input type="checkbox"/> Non-Drinker	<input type="checkbox"/> Occasional/Social <input type="checkbox"/> Frequent/Regular
Recreational Drug Use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Exercise: <input type="checkbox"/> None <input type="checkbox"/> 1-2 times/week <input type="checkbox"/> 3 or more times/week	
Sexually Active? <input type="checkbox"/> No <input type="checkbox"/> Yes Length of time with current partner: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married – How long: _____	
<input type="checkbox"/> Divorced <input type="checkbox"/> In a Relationship – How long: _____	

Review of Systems: Please check the boxes of any symptoms you are currently experiencing.

Head/Eyes	<input type="checkbox"/> Headache	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Visual Problems
Endocrine	<input type="checkbox"/> Excess Thirst	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance
	<input type="checkbox"/> Increased Appetite	<input type="checkbox"/> Decreased Appetite	
Cardiovascular	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Palpitations
Gastrointestinal	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Blood in Stool
Genitourinary	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Frequency	<input type="checkbox"/> Urgency
	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Blood in Urine	
Musculoskeletal	<input type="checkbox"/> Muscle Swelling	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain
Psychological	<input type="checkbox"/> Depression	<input type="checkbox"/> Crying Spells	<input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Anxiety
	<input type="checkbox"/> Mood Instability	<input type="checkbox"/> Attention Problems	

Last Mammogram (Date): _____ Location: _____

Topics for Today's Visit (check all that you wish to discuss):

Prevention	Infectious Disease/Cancer
Alcohol screening & counseling	Gonorrhea & Chlamydia
Aspirin use	Hepatitis B
Blood pressure	Hepatitis C
Contraception	HIV risk assessment
Depression	HIV testing
Diabetes	Immunizations
Folic acid supplementation	Latent tuberculosis
Healthful diet and activity	STI prevention
Interpersonal violence	Syphilis
Lipid screening	Breast cancer
Obesity	Cervical cancer
Osteoporosis	Colon cancer
Prevention of falls	Lung cancer
Statin use	Medications to reduce breast cancer
Substance use	Risk assessment for BRCA testing
Tobacco screening & counseling	Skin cancer
Urinary incontinence	

BLOSSOM

GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
MARJORIE A. CHORNESS, MD FACOG

Today's date	Social Security #	DOB: / /	
PATIENT INFORMATION			
Last Name	First	MI	Address
City/State	Zip Code	Home #	Cell #
Employer	Employer Address	Work #	Pharmacy #
Email Address		Primary Care Physician	
Marital Status <input type="checkbox"/> S- Single <input type="checkbox"/> M- Married <input type="checkbox"/> D-Divorced <input type="checkbox"/> X- Separated <input type="checkbox"/> W- Widow		Employed <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> R- Retired <input type="checkbox"/> Self <input type="checkbox"/> N- None	
		Student <input type="checkbox"/> FT <input type="checkbox"/> PT	

INSURANCE INFORMATION (We must have this information in order to file your insurance)					
Primary Insurance Co:					
Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	ID #	Group #	Co-Pay \$
Patient's relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Subscriber's Employer		Employer Address		Employer Phone #	
Secondary Insurance Co:					
Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	ID #	Group #	Co-Pay \$
Patient's relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Subscriber's Employer		Employer Address		Employer Phone #	

INSURANCE AUTHORIZATION AND ASSIGNMENT	
I hereby authorize BLOSSOM Gynecology, Wellness & Infertility (Dr. Marjorie Chorness) to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.	
_____ <i>Patient/Guardian signature</i>	_____ <i>Date</i>

BLOSSOM

GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

<i>children</i>			
NAME	AGE	NAME	AGE

PERSONAL INTERESTS

LEVEL OF EDUCATION
<input type="checkbox"/> High School <input type="checkbox"/> College 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Post Graduate <input type="checkbox"/> Other

PATIENT CONTACT PREFERENCES	
I give Blossom Gynecology, Wellness & Infertility, P.A. permission to contact me in the following way:	
Home Phone <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Phone <input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail <input type="checkbox"/> Yes <input type="checkbox"/> No
E-Mail Address: _____	

With the following information:			
Appointment Information <input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Information <input type="checkbox"/> Yes <input type="checkbox"/> No		
Lab Results <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance/Billing <input type="checkbox"/> Yes <input type="checkbox"/> No		

EMERGENCY CONTACT				
Name	Relationship	Home #	Cell #	Work #

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
MARJORIE A. CHORNESS, MD FACOG
420 C THE PARKWAY • GREER, SC 29650 864.662.5000 FAX 864.662.5008

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Blossom Gynecology, Wellness & Infertility, P.A. to use and/or disclose my protected health information as described below to

(name and address of recipient) _____

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)

I understand that:

- 1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- 3) I may revoke this authorization at any time by notifying Blossom Gynecology, Wellness & Infertility, P.A. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- 4) Blossom Gynecology, Wellness & Infertility, P.A. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

Entire Medical Record	Most Recent 5 Year History	Radiology Reports
Office Chart Notes	All Hospital Records	Operative Reports
Billing Statements	Transcribed Hospital Reports	Other _____
Dental Records	History and Physical Exam	_____
Laboratory Reports	Emergency and Urgent Care Records	_____
Pathology Reports	Medical Records for Continuity of Care	_____
Consultation	Diagnostic Imaging Reports	_____
Discharge Summary	Emergency Room Reports	_____

In addition, I authorize that this will include health information relating to (check if applicable):

HIV/AIDS infection Drug/Alcohol abuse Genetic Testing

Expiration:

This authorization will expire 365 days from the date of signing.

Patient Name: _____	Patient ID #: _____
Signature of Patient or Legal Representative _____	Date _____
Signature of Witness _____	Date _____

Blossom Gynecology, Wellness and Infertility, PA
Marjorie A. Chorness, MD FACOG
420 The Parkway, Suite C
Greer, SC 29650

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient DOB: _____

I hereby acknowledge that I have received/reviewed a copy of Notice of Privacy Practices for Blossom Gynecology, Wellness and Infertility, PA. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)
Parent or guardian of unemancipated minor
Court appointed guardian
Executor or administrator of decedent's estate
Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,
_____ but acknowledgment could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time
(will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

Other (Specify)

Marjorie A. Chorness, MD FACOG
420 The Parkway, Suite C
Greer, SC 29650
Tel: (864) 662-5000

PATIENT CONSENT FOR TREATMENT

I have requested medical and/or surgical services from Blossom Gynecology & Infertility, P.A. ("Blossom Gynecology") and by signing below, I voluntarily consent to treatment by Blossom Gynecology personnel, including any physician and/or any other designee who may be involved in performing evaluation, lab tests (which may include using drug screens and testing for HIV or other sexually transmitted diseases), physical exam, ultrasound, biopsy, administration of medication, and procedures. This consent will remain in place until I revoke the consent in writing or until the law states that it has expired. Any action taken in reliance on this consent prior to the revocation or expiration of this consent will remain valid.

I understand that I have the right to speak with the physician before any treatment or procedure, and I have been offered the opportunity to ask any questions about the care I may or may not elect to receive. I am aware that the practice of medicine, surgery, and gynecology is NOT an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of any treatment. I understand and agree that Blossom Gynecology may, at its sole discretion, terminate the physician patient relationship in the event that I fail to follow physician orders that are critical to my care and well-being. Failure to follow physician orders includes, but is not limited to, failing to keep scheduled appointments with Blossom Gynecology; failing to keep appointments for lab draws; failing to take prescribed medications; failing to attend imaging appointments, including, but not limited to mammograms and pelvic ultrasounds; and, failing to attend medical appointments when referred outside of the Blossom Gynecology.

Blossom Gynecology is an office-based gynecology practice that does not provide emergency or hospital services. I understand that if I require hospitalization, inpatient services, or specialized services beyond the scope of Blossom Gynecology's practice, Blossom Gynecology will refer me to a different physician for further treatment. If I require immediate hospital or emergency care, Blossom Gynecology will send me to a hospital emergency department or direct me to call 911.

Blossom Gynecology is at times involved in health care education, and I agree that unless I specifically request otherwise, at times, care, examination, and treatment may be delivered by students or medical personnel in training who are under the supervision of a physician.

I understand and agree that my treatment or procedure may be photographed and/or videotaped. I understand that these materials will be used for medical, scientific, or education purposes provided my identity is not revealed by the pictures or by descriptive accompanying text. I understand and agree not to photograph, videotape, audiotape, record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, AND THEY HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ AND EXPLAINED TO ME. I UNDERSTAND THIS FORM AND I HEREBY AGREE TO ALL TERMS AND CONDITIONS SET FORTH ABOVE. I VOLUNTARILY CONSENT TO ALLOW BLOSSOM GYNECOLOGY, ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF ITS PHYSICIANS, AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN MY CARE TO PERFORM TREATMENT.

_____	Patient Signature	Date	_____
_____	Witness Signature	Date	_____
_____	Parent/Guardian Signature*	Date	_____

**Parent/Guardian's signature is not required if the patient is 16 years old or above and the procedure does not involve an operation in accordance with S.C. Code Ann. 63-5-340.*

Family history questionnaire

Personal Information

Patient name	Date of birth	Healthcare provider	Today's date
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Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.** For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of: Yes (Y) / No (N) Which cancer? Age at diagnosis?

Breast, ovarian, colon, rectal or pancreatic cancer at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Uterine cancer at 64 or younger	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have family history of: Yes (Y) / No (N) Maternal (M) Paternal (P) Which relative? Age at diagnosis?

Breast cancer at 50 or younger	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Two different breast cancers in one relative at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Three breast cancers in relatives on the same side of the family at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Ovarian cancer at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Male breast cancer at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Triple negative breast cancer at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Ashkenazi Jewish ancestry with breast cancer at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Pancreatic cancer at any age (1st-degree relative)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Colon cancer at 49 or younger (1st-degree relative)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Uterine cancer at 49 or younger (1st-degree relative)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		
Three colon and/or uterine cancers on the same side of the family at any age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> P		

Do you have family history of other cancers? List them here:

Have you or anyone in your family had genetic testing for hereditary cancer?	What?	What gene?	Result?
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Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature	Date
Healthcare provider signature	Date

Office use only Patient offered hereditary cancer genetic testing? Yes No / Accepted Declined

If yes, which test? BRACAnalysis® with MyRisk® / Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk®
 COLARIS® PLUS with MyRisk® / COLARIS AP® PLUS with MyRisk® / Single site testing / MyRisk® Update Test
 Other: _____

Follow-up appointment scheduled? Yes No Date of next appointment: _____

Name _____ DOB _____ Date _____

Menopause Rating Scale

Which of the following symptoms apply to you at this time?

		None	mild	moderate	severe	extremely severe	how long?
1. Hot flashes	Times per day? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Night sweats	Times per night? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Sleep problems (difficulty falling asleep, difficulty sleeping through the night, waking up early)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Depressive mood		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Irritability (feeling nervous, inner tension, feeling aggressive)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Mood swings		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Anxiety (inner restlessness, feeling panicky)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Sexual problems (change in sexual desire, in sexual activity and satisfaction)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Bladder problems (difficulty in urinating, increased need to urinate, incontinence)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Vaginal dryness or burning, difficulty with sexual intercourse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Joint and muscular discomfort		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Weight Gain	How much? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you currently using hormone replacement therapy? ___Yes ___No

Used in the past? ___Yes ___No

If yes, what type (cream, pellet, patch, ring, etc) and for how long? _____

Physician notes: _____

BLOSSOM GYNECOLOGY FINANCIAL POLICIES

Thank you for choosing Blossom Gynecology, Wellness & Infertility, P.A. as your healthcare provider. We are committed to building a successful and long-term physician-patient relationship.

Insurance: A valid photo ID/Drivers License and active insurance card must be presented at the time of your visit. As the insured member, it is the patient's responsibility to understand the coverage details of the policy and to verify we are participating providers. Deductibles, co-insurances and co-pays, as outlined by your policy, are due at time of service.

Preventative Visits: A Well Woman Visit is considered preventive care and includes history taking, breast and pelvic exam, as well as necessary testing including a pap smear.

Problem Visits and Procedures: A physician may determine it is necessary to spend additional time and/or perform procedures to fully address problems at a visit, or at the time of a Preventative visit. The additional charges are billed to your insurance company and will be reflected on the Explanation of Benefits you receive from your insurance carrier. Acceptance of a partial payment from the insurance company does not waive the right of Blossom Gynecology to collect full payment.

Non-Covered Services: Payment will be due at time of service. Should you have any questions on what services are non-covered, we encourage you to contact your insurance company. If your insurance was inactive at the time of your visit, you will be responsible for the total cost. Elective, cosmetic, or aesthetic procedures will be the patient's financial responsibility and are non refundable.

Overdue Accounts: If the balance is not paid within 30 days of the date of service your account is considered past due and we reserve the right to forward the account to a collection agency. The patient/guarantor of the account will assume all costs of collections, interest, and legal fees, up to 50% of the account balance. Any questions regarding balances can be emailed to patientaccounts@blossomgyn.com. In the event the account is no longer current, medical services may be discontinued.

Additional Fees: A \$40.00 fee will be charged for the following: medication renewals outside of a scheduled appointment; prior authorizations; letters/forms; missed appointments unless cancelled/rescheduled 24 hours prior to your visit.

Outside Services: Charges for services performed by Quest, LabCorp and Myriad are handled directly by billing departments associated with these companies. Any questions should be directed to the billing phone number provided by these companies.

By signing below, I understand and agree to the financial policy as outlined above. I consent to receiving emails, text messages and phone contact regarding financial matters.

Patient/Guardian Signature

Date

Patient/Guardian Printed Name

E-mail Address