PEDIATRIC HEALTH PARTNERS, S.C.

CHRISTINE BOYD, M.D., F.A.A.P.,
JAMIE R. SHARMA, D.O., F.A.A.P., REBECCA CHOLST, M.D., F.A.A.P.

INFORMATION SHEET – PLEASE PRINT-IF NOT APPLICABLE, PLEASE LEAVE BLANK

PATIENT'S FULL NAME: ____

DATE OF BIRTH: ________________________ **GENDER:** ________________

REQUIRED FOR EMR (ELECTRONIC MEDICAL RECORD)

PLEASE CIRCLE:

RACE: White, Asian, Black or African American, Hispanic, Native Hawaiian or other Pacific, Other Pacific Islander, Other Race, Decline to Report

ETHNICITY: Hispanic or Latin, Not Hispanic or Latin, Decline to Report

LANGUAGE: English, Other ______________________________

HOME ADDRESS: ____

____

HOME PHONE NO: (______) ____

CELL NUMBER: (_______) ____

PARENT 1: ____

S.S. # _________-________-__________ **D.O.B.:** ___________________________

HOME ADDRESS IF DIFFERENT ____

____

HOME PHONE NO: (______) ______________ **CELL PHONE NO:** (______) ____________

OCCUPATION: ____

EMPLOYER: ___________________________ **WK PHONE NO:** (_______) ____________

EMPLOYER ADDRESS: ____

PARENT 2: ____

S.S. # _________-________-__________ **D.O.B.:** ___________________________

HOME ADDRESS IF DIFFERENT ____

____

HOME PHONE NO: (______) ______________ **CELL PHONE NO:** (______) ____________

OCCUPATION: ____

EMPLOYER: ___________________________ **WK PHONE NO:** (_______) ____________

EMPLOYER ADDRESS: ____

EMERGENCY CONTACT: (OTHER THAN PATIENT'S PARENT)

NAME: _________________________________ **PHONE NO:** (_______) _______________

RELATIONSHIP: __________________________ **CELL NO:** (_______) _______________

PATIENT'S FULL NAME: ________________________________

DATE OF BIRTH: ____________________ **M** __________ **F** __________

RESPONSIBLE PARTY FOR BILLING

NAME: ______________________ **RELATIONSHIP TO PT:** ______________

ADDRESS IF DIFFERENT: ________________________________

PHONE NO. IF DIFFERENT:(________ **)** __________ **CELL NO.(** ______ **)** __________

****

PRIMARY INSURANCE:

NAME OF INSURANCE: ________________________________

SUBSCRIBER NAME: __________________ **EFFECTIVE DATE:** __________

POLICY # ______________________ **GROUP #** __________________

CO-PAY $ __________ **CO-PAYS MUST BE PAID AT THE TIME SERVICE IS RENDERED.**

SECONDARY INSURANCE:

(OUR OFFICE DOES NOT ACCEPT MEDICAID AS SECONDARY INSURANCE)

NAME OF INSURANCE: ________________________________

SUBSCRIBER NAME: __________________ **EFFECTIVE DATE:** __________

POLICY # ______________________ **GROUP #** __________________

CO-PAY $ __________ **CO-PAYS MUST BE PAID AT THE TIME SERVICE IS RENDERED.**

IF PREVIOUS INSURANCE TERMINATED:

NAME OF PREVIOUS INSURANCE: ________________ **TERMINATION DATE:** __________

A COPY OF YOUR CURRENT INSURANCE CARD MUST BE ON FILE AND PRESENTED AT EACH VISIT FOR VERIFICATION PURPOSES. If you do not have a current insurance card with you or verification of insurance, the billing is considered self pay until the information is received. **EVERYTHING NOT COVERED BY THE INSURANCE PLAN IS YOUR FINANCIAL RESPONSIBILITY.** Please read your health care manual to be familiar with your insurance policy regarding coverage, regulations and restrictions. Contact our office if you have a question regarding participation in a specific insurance plan.

I AUTHORIZE PAYMENT FROM ANY OF MY INSURANCE COMPANIES TO PEDIATRIC HEALTH PARTNERS, S.C. FOR SERVICES RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL AND OTHER INFORMATION NECESSARY TO PROCESS ANY CLAIM. IN CONSIDERATION OF MEDICAL SERVICES, I AGREE TO PAY PEDIATRIC HEALTH PARTNERS, S.C. FOR ANY BALANCE DUE. A PHOTOCOPY OF THIS AGREEMENT IS VALID.

SIGNED: ________________________ **DATE:** ____________________

CONSENT FOR MINORS:

I CONSENT FOR MY MINOR DEPENDENT TO RECEIVE OFFICE CARE INCLUDING ROUTINE PROCEDURES AND MEDICAL TREATMENT PERFORMED BY THE ATTENDING PHYSICIAN, HER ASSISTANT OR DESIGNEES, AS MAY BE NECESSARY IN HER MEDICAL JUDGEMENT, EVEN IN THE EVENT MY CHILD IS UNACCOMPANIED BY MYSELF, THE OTHER PARENT OR LEGAL GUARDIAN. I AGREE TO THE FINANCIAL POLICIES AS DESCRIBED ABOVE.

________________________________ **DATE:** ____________________

PARENT / GUARDIAN SIGNATURE

****Persons 17 years or younger may provide consent for him/herself if s/he is married, pregnant, a parent, seeking care for sexually transmitted disease, family planning, substance abuse or presents a court order of legal emancipation.***

FOR OFFICE USE ONLY:

RECEIVED BY: ____________ ***ENTERED IN COMPUTER BY:*** __________ ***DATE ENTERED:*** __________

PEDIATRIC HEALTH PARTNERS, S.C.
10436 Southwest Highway, Suite 2
Chicago Ridge, IL 60415
708-636-0700; Fax #708-636-3849

PHARMACY INFORMATION

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Pharmacy Name: ______________________________

Pharmacy Address: ______________________________

____

Pharmacy Telephone Number: (______) ______________________

Pharmacy Fax Number: (______) ______________________

Pediatric Health Partners, S. C.

Receipt of Notice of Privacy Practices Form

I hereby give my consent to Pediatric Health Partners, S. C. to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of

Patient Name ______________________________ Birthdate ______________

Patient Name ______________________________ Birthdate ______________

Patient Name ______________________________ Birthdate ______________

Patient Name ______________________________ Birthdate ______________

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: ______________________________ Date: ______________

Print Name: ______________________________

If you are not the patient, please specify your relationship to the patient:

____

(Parent / Legal Guardian / Legal Representative)

* To Patient's File

FOR OFFICE USE ONLY

DATE RECEIVED ____________ INITIAL ________

Advocate Physician Partners

SynAPPs

Specially Protected Health Information Authorization Form

Authorization to use and/or disclose protected health information in the Electronic Health Information Exchange.

____YES. I authorize this practice to use and/or disclose a copy of my protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw permission my protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

____

Authorized date(s) or date range

____

Printed Name of Patient/Representative

______________________________ ______________

Signature of Patient/Representative Date

AUTHORIZATION OF REPRESENTATIVE:

I,______________________________, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient ______________________________

[A signed copy of this permission will be provided to the patient/representative]

Advocate Physician Partners

SynAPPs

Notificaton: Opting out of eEHX-

Electronic Health Information Exchange and/or Illinois' Immunization Registry

_______NO. I do not want my Health Information included in the electronic Health Information Exchange as described above.

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the electronic Health Information Exchange.

I understand that I am withdrawing permission for sharing my Health Information by signing this notice and submitting it to the practice manager of my physician's office. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire if the electronic Health Information Exchange program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have indicated "NO" to sharing of my Health Information, I understand that an electronic Health Information Exchange record will not be available to other providers.

_______ I request that my immunization information be removed from the Illinois Immunization Registry. I understand the state will not share immunization data on me from the registry as a result of this action. The registry will retain core demographic information necessary to identify that I have chosen to opt out of the registry. This information is necessary for the registry to be able to filter and refuse entry of immunization information for me. Additionally, any prior immunization records associated with me will not be shared from the registry. No immunization information will be added to the registry for me until the Illinois Immunization Program receives notification that I wish to opt back into the registry. To opt back in, a separate opt in form must be completed.

____

Printed Name of Patient/Representative

______________________________________ ____________________

Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, ______________________________________, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient: ______________________________________

[A signed copy of this permission will be provided to the patient/representative. **Please place a copy of this form in the patient's medical chart.]**

Welcome to eEHX

This office is taking an exciting step forward in providing you and your family with improved health care. We are now participating in an electronic Health Information Exchange, known as eEHX, in which important information about your care can be electronically and securely shared between this practice and other Advocate physicians involved in your care. This allows us to better coordinate the care that you may receive from a number of participating physicians (primary care physicians and specialists).

How Does eEHX Improve the Care I Receive?
eEHX helps your physician provide you with the best care possible by making all of your basic health information available in one secure location. This basic health information includes your medical problems, medications and allergies. Here are a few of the specific benefits of eEHX for patients.

- Your health and medical history can be accessed quickly and securely by other participating Advocate physicians from whom you receive care.
- Participating Advocate physicians can more effectively collaborate to provide you with more comprehensive care.
- When needed, your records will not need to be mailed, faxed or hand-carried to other physicians within the system. Your records will flow electronically to other physicians providing care to you.

This is particularly beneficial if:
- You are treated by more than one physician.
- You regularly take one or more medications.
- You have food, medical or other allergies.
- In an emergency, all your physicians have access to your vital health information.

Health care research shows that information sharing leads to:
- Reduction of duplicate labs and imaging tests
- Reduction of medical errors
- Improved coordination of care
- Improved quality of care

What if I Have Questions about eEHX?
If you have questions about how your health information is used in eEHX or what information is included, please speak with your physician or another person in your physician's office. Here are answers to some commonly asked questions.

Q: How Does eEHX Work?
A: eEHX allows your physician to securely copy your health information from his or her electronic medical records application into eEHX. This information can then be accessed and imported into another physician's electronic application when that physician is caring for you.

Q: What Kind of Information is Shared?
A: The information in eEHX includes your demographic information such as name and gender, diagnostic assessments, medications, immunizations, lab results, diagnostic imaging results, referrals and procedures. Your patient summary will also be shared and includes advanced directives, allergies, surgical history, hospitalization history, family history and treatment plan. If you have questions about any of this information, please ask your physician.

The following information is defined by the State of Illinois as specially protected health information and will not be shared in eEHX without your written permission: information concerning alcoholism treatment, drug abuse treatment, mental health services, developmental disability services, genetic testing and treatment, HIV/AIDS/sexually transmitted disease testing and treatment, child abuse/neglect treatment and treatment of sexual assault or abuse.

continued on back...

Q: What If I Do Not Want My Health Information Shared?
A: If you do not want your information included in this program, please inform the person who checks you in for your appointment or your physician. You will be asked to sign **an eEHX opt-out consent form** stating that you do not want your basic health information included in eEHX.

Q: What If I Decide at a Later Date That I Don't Want My Information Shared?
A: Again, you will be asked to sign a form documenting your wishes to stop having your basic health information shared in eEHX. Please note that information which is already in eEHX will remain in the system but will not be accessible by anyone. No new information about you will be added to eEHX.

If you have questions about how your health information is used in eEHX or what information is included, please speak with your physician or another person in your physician's office.

Advocate Health Care

2025 Windor Drive || Oak Brook, IL 60523
1.800.3.ADVOCATE (1.800.323.8622)
advocatehealth.com

17-8137

PEDIATRIC HEALTH PARTNERS, S.C.
10436 Southwest Highway
Chicago Ridge, IL 60415
Ph: 708.636.0700 Fax 708.636.3849

NO SHOW AND CANCELLATION POLICY

CANCELLATION OF APPOINTMENT

In order to be respectful of the medical needs of our patients, please be courteous and call promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your scheduled appointment, we require that you call 24 business hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

HOW TO CANCEL YOUR APPOINTMENT

To cancel appointments, please call 708.636.0700- After office hours, please leave a message with our answering service.

LATE CANCELLATIONS

Late cancellations will be considered as a "no show".

NO SHOW POLICY

A "NO SHOW" is someone who misses an appointment without cancelling it 24 business hours in advance of your scheduled appointment. A failure to present at the time of a scheduled appointment will be recorded in the chart as a "no-show" and we will send a letter to alert you and keep a copy in your file. If there is a second "no show' there will be a $25.00 charge billed to your home. This fee covers the administrative tasks associated with your appointment and is not covered by your insurance.

Effective January 1st, 2022

Advocate Physician Partners

SynAPPs

HIPAA Privacy Statement - Addendum

This practice participates in a Health Information Exchange program where key clinical information about our patients' care is shared electronically, through a secure web portal, between this practice and other physicians/providers also providing care to our patients. Basic health information is shared with other treating physicians and providers. Sharing of basic health information in a Health Information Exchange is done so to have information available to better care for patients and the information is used for no other purposes.

LATER, if you decide that you no longer wish to participate, any information in The Health Information Exchange cannot be removed, but it will not be viewable because the patient identifying information will be inactivated. If you wish to exclude your basic health information from being included in this program, please inform the practice manager. You will be asked to sign a form documenting your wishes to "Opt-out".

The following information is defined by the State of Illinois as specially protected health information and should ***only***be shared with the patient's written permission in the Health Information Exchange, eEHX. This specially protected information includes information concerning alcoholism treatment, drug abuse treatment, mental health services, developmental disabilities services, genetic testing and treatment, testing and treatment for HIV/AIDS/Sexually Transmitted Disease, treatment for child abuse/neglect, and treatment of sexual assault or abuse.

We have taken precautions to try and exclude this information from the Health Information Exchange, but there still is a small possibility that this information may be inadvertently sent to the HIE. **Therefore, if you have specially protected health information you should "Opt-out" of participating in the eEHX, or sign a consent that allows release of your specially protected health information.**

This practice also participates with the **Illinois State Immunization Registry and Public Health Disease Surveillance Registry**. Information will be sent electronically to the IL State registries about immunizations and state-required reportable diseases. This information is used by the State of IL to track Public Health needs. If you do not want your immunization information to be reported to the IL State Immunization Registry you may request to "Opt out" of this by signing an Opt-out form. This will not affect your care by your doctor.

Pediatric Health Partners S.C. **April 14, 2003**

NOTICE OF PRIVACY PRACTICES

(As required by the privacy regulations created as a result of The Health Insurance Portability and Accountability Act of 1996 -HIPAA)

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.

The practice acts to maintain the privacy of protected health information and provide individuals with notice of the practice's legal duties and privacy practices with respect to protected health information as described in this Notice and abide by the terms of the Notice currently in effect.

Provision of Notice: The practice provides its Notice of Privacy Practices to every patient with whom it has a direct treatment relationship. The Notice is provided no later than the date of the first treatment to the patient after April 14, 2003.

The practice makes its Notice available to any member of the public to enable prospective patients to evaluate the practice's privacy practices when making his or her decision regarding whether to seek treatment from the practice. The practice provides its Notice via e-mail to any patient or other individual who so requests the Notice.

Documentation of Provision of Notice: When a direct treatment patient receives the Notice from the practice, the practice asks the patient to sign its "Receipt of Notice of Privacy Practices" form. The form is filed with the patient's medical record. If the patient refuses to sign the form, it is noted in the medical record that the patient was given the Notice and refused to sign the form.

Effective Date and Changes to Notice: This Notice is effective April 14, 2003. The practice reserves the right to revise this Notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or other privacy practices stated in the Notice. Except when required by law, a material change to any term of the Notice will not be implemented prior to the effective date of the notice in which such material change is reflected.

If the Notice is revised, the practice makes the revised Notice available upon request beginning on the revision's effective date. The revised notice is posted in the practice's reception area and made available to all patients, including those who have received a previous Notice. Upon receipt of a revised Notice, a patient is asked to acknowledge receipt of the Notice.

Complaints: The practice allows all patients and their agents to file complaints with the practice and with the Secretary of the federal Department of Health and Human Services (DHHS). A patient or his or her agent may file a complaint with the practice whenever he or she believes that the practice has violated their rights.

Complaints to the practice must be in writing, must describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware or should have become aware of the violation. Complaints must be addressed to the attention of the practice's privacy officer at the practice's address. The practice investigates each complaint and may, at its discretion, reply to the patient or the patient's agent.

Complaints to the Secretary of the Department of Health and Human Services must be in writing, must name the practice, must describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware or should have become aware of the violation. Complaints must be addressed to: Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, Ill. 60601, Voice Phone (312) 886-2359, FAX (312) 886-1807, TDD (312) 353-5693.

The practice does not take any adverse action against any patient who files a complaint (either directly or through an agent) against the practice.

Contact Person: The practice has a privacy officer that serves as the contact person for all issues related to the Privacy Rule. If you have any questions about this Notice, please contact privacy officer at 708-636-0700.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The practice reasonably ensures that the protected health information (PHI) it requests, uses, and discloses for any purpose is the minimum amount of PHI necessary for that purpose.

The practice treats all qualified individuals as personal representatives of patients. The practice generally allows individuals to act as personal representatives of patients. The two general exceptions to allowing individuals to act as personal representatives relate to unemancipated minors and abuse, neglect, or endangerment situations.

The practice makes reasonable efforts to ensure that protected health information is only used by and disclosed to individuals that have a right to the protected health information. Toward that end, that practice makes reasonable efforts to verify the identity of those using or receiving protected health information.

Uses and Disclosures – Treatment, Payment, and Health Care Operations

The practice uses and discloses protected health information for payment, treatment, and health care operations. *Treatment* includes those activities related to providing services to the patient, including releasing information to other health care providers involved in the patient's care. *Payment* relates to all activities associated with getting reimbursed for services provided, including submission of claims to insurance companies and any additional information requested by the insurance company so they can determine if they should pay the claim. *Health care operations* includes a number of areas, including quality assurance and peer review activities.

Uses and Disclosures – Not Requiring Authorization

Disclosure to Those Involved in Individual's Care: The practice discloses protected health information to those involved in a patient's care when the patient approves or, when the patient is not present or not able to approve, when such disclosure is deemed appropriate in the professional judgment of the practice.

When the patient is not present, the practice determines whether the disclosure of the patient's protected health information is authorized by law and if so, discloses only the information directly relevant to the person's involvement with the patient's health care.

The practice does not disclose protected health information to a suspected abuser, if, in its professional judgment, there is reason to believe that such a disclosure could cause the patient serious harm. Further, the practice uses and discloses information as required by law.

Uses and Disclosures Required by Law: The practice uses and discloses protected health information to appropriate individuals as required by law.

As required by law the practice discloses protected health information to public health officials. This includes reporting of communicable diseases and other conditions, sexually transmitted diseases, lead poisoning, Reyes Syndrome, and mandated reports of injury, medical conditions or procedures, or food-borne illness including but not limited to adverse reactions to immunizations, cancer, adverse pregnancy outcomes, death, birth.

The practice discloses protected health information regarding victims of abuse, neglect, or domestic violence. The practice discloses information about a minor, disabled adult, nursing home resident, or person over 60 years of age whom the practice reasonably believes to be a victim of abuse or neglect to the appropriate authorities as required by law or, if not required by law, if the individual agrees to the disclosure. This includes child abuse and neglect, elder abuse and exploitation, abused and neglected nursing home residents, or disabled adults abuse.

The practice informs the individual of the reporting unless the practice, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm or the practice would be informing a personal representative, and the practice believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the professional judgment of the practice.

Uses and Disclosures for Health Oversight Activities: The practice uses and discloses PHI as required by law for health oversight activities. The information may be used and released for audits, investigations, licensure issues, and other health oversight activities, including, but not limited to hospital peer review, managed care peer review, or Medicaid or Medicare peer review.

Disclosures for Judicial and Administrative Proceedings: In general, the practice discloses information for judicial and administrative proceedings in response to an order of a court or an administrative tribunal; or a subpoena, discovery request or other lawful process, not accompanied by a court order or an ordered administrative tribunal.

Disclosures for Law Enforcement Purposes: The practice discloses PHI for law enforcement purposes to law enforcement officials.

Uses and Disclosures Related to Decedents: The practice uses and discloses PHI as required to a coroner or medical examiner and funeral directors as required by law. The attending physician is required to sign the death certificate and provide the coroner with a copy of the decedent's protected health information.

Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations: The practice uses and discloses protected health information to facilitate organ, eye or tissue donations.

Uses and Disclosures to Avert a Serious Threat to Health or Safety: The practice uses and discloses protected health information to public health and other authorities as required by law to avert a serious threat to health or safety.

Uses and Disclosures for Specialized Government Functions: The practice uses and discloses protected health information for military and veterans activities, national security and intelligence activities, and other activities as required by law.

Uses and Disclosures in Emergency Situations: The practice uses and discloses protected health information as appropriate to provide treatment in emergency situations. In those instances where the practice has not previously provided its Notice of Privacy Practices to a patient who receives direct treatment in an emergency situation, the practice provides the Notice to the individual as soon as practicable following the provision of the emergency treatment.

Marketing Purposes: The practice does not use or disclose any protected health information for marketing purposes. The practice *does* engage in communications about products and services that encourages recipients of the communication to purchase or use the product or service for treatment, to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual. These activities are not considered marketing.

In addition, the practice may contact the individual with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Uses and Disclosures – Do Not Apply to Practice

Research: Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver pf upir authorization satisfies the following: (i) the use or disclosure involved no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (Except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise by permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

Other Uses and Disclosures: The practice does not use or disclose protected health information to an employer or health plan sponsor, for underwriting and related purposes, for facility directories, to brokers and agents, or for fundraising.

If an individual wants the practice to release his or her protected health information to employers or health plan sponsors, for underwriting and related purposes, for facility directories, or to brokers and agents, then he or she can contact the practice and complete an appropriate written authorization.

INDIVIDUAL RIGHTS

Individual Rights – Accounting for Disclosures of Protected Health Information

The practice tracks all disclosures of a patient's protected health information that occur for other than the purposes of treatment, payment, and health care operations, that are not made to the individual or to a person involved in the patient's care, that are not made as a result of a patient authorization, and that are not made for national security or intelligence purposes or to correctional institutions or law enforcement officials.

The practice allows an individual to request one accounting within a 12-month period free of charge. The practice charges a reasonable fee for more frequent accounting requests An individual can request an accounting of disclosures for a period of up to six years prior to the date of the request. Requests for shorter accounting periods will be accepted. However, patients may only request an accounting of disclosures made on or after April 14, 2003.

The practice responds to all requests for an accounting of disclosures within 60 days of receipt of the request. If the practice intends to provide the accounting for disclosures and cannot do so within 60 days, the practice informs the requestor of such and provides a reason for the delay and the date the request is expected to be fulfilled. Only one 30-day extension is permitted.

A request for an accounting for disclosures must be made in writing and mailed or sent to the practice. It should be marked "Attention: Privacy Officer."

Individual Rights – Inspect and Copy Protected Health Information

The practice allows individuals to inspect and copy their protected health information, documents all requests, responds to those requests in a timely fashion, informs individuals of their appeal rights when a request is rejected in whole or in part, and charges a reasonable fee for the copying of records.

The practice reviews the request in a timely fashion and acts on a request for access generally within 30 days. The practice may have a single extension of 30 days, if needed to act on the request. Each request will be accepted or denied and the requestor notified in writing. If a request is denied, the requestor is informed if the denial is "reviewable" or not. The requestor has the right to have any denial reviewed by a licensed health care professional who is designated by the practice as a reviewing official and who did not participate in the original decision to deny. The practice informs the requestor of the decision of the reviewing official and adheres to the decision.

The practice charges reasonable fees based on actual cost of fulfilling the request. The practice will determine the appropriate charge for providing the requested records and inform the requestor in advance of providing the records. If the requestor agrees to pay the fee in advance, the records will be provided. Otherwise, the records will not be provided, unless the Privacy Officer determines that the charge is burdensome to the requestor.

Illinois law prohibits charges that exceed the following: $20.48 handling fee plus 77 cents each for pages 1-25, 51 cents each for pages 26-50, and 26 cents each for pages 51 to end; plus actual expenses related to the copying of x-rays, CAT scans, and similar. The practice limits charges for records to the amounts allowed under Illinois law.

Requests for the inspection and copying of records must be sent to the practice in writing. It should be marked "Attention: Privacy Officer."

Individual Rights – Request Amendment to Protected Health Information

The practice allows an individual to request that the practice amend the protected health information maintained in the patient's medical record or the patient's billing record. The practice documents all requests, responds to those requests in a timely fashion, and informs individuals of their appeal rights when a request is denied in whole or in part.

Generally the practice will act on a request for amendment no later than 60 days after receipt of such a request. If the practice cannot act on the amendment within 60 days, the practice extends the time for such action by 30 days and, within the 60-day time limit, provides the requestor with a written statement of the reasons for the delay and the date by which the practice will complete action on the request. Only one such extension is allowed.

If the practice denies the request, in whole or in part, the practice provides the requestor with a written denial in a timely fashion. The practice allows a requestor to submit a written statement disagreeing with the denial of all or part of the initial request. The statement must include the basis of the disagreement. The practice limits the length of a statement of disagreement to one page.

The practice accepts requests to amend the PHI maintained by the practice. The requests must be in writing and should be marked "Attention: Privacy Officer."

Individual Rights – Request Confidential Communications

The practice accommodates all reasonable requests to keep communications confidential. The practice determines the reasonableness based on the administrative difficulty of complying with the request.

A request for confidential communications must be in writing and on the practice's Request for Confidential Communications form, must specify an alternative address or other method of contact, and must provide information about how payment will be handled. The request must be addressed to the practice's privacy officer. No reason for the request needs to be stated.

The practice accommodates all reasonable requests. The reasonableness of a request is determined solely on the basis of the administrative difficulty of complying with the request. The practice will reject a request due to administrative difficulty: if no independently verifiable method of communication such as a mailing address or published telephone number is provided for communications, including billing; or if the requestor has not provided information as to how payment will be handled.

The practice will not refuse a request: if the requestor indicates that the communication will cause endangerment; or based on any perception of the merits of the requestor's request.

Individual Rights – Request Restriction of Disclosures

The practice accepts all requests for restrictions of disclosures of protected health information. The practice does not agree to any restrictions in the use or disclosure of protected health information.

All requests for restrictions of disclosures must be submitted in writing. They must be sent to the attention of the practice's privacy officer. The privacy officer notifies the requestor in writing that the practice does not accept restrictions of disclosure.

Individual Rights – Authorizations

The practice obtains a written authorization from a patient or the patient's representative for the use or disclosure of protected health information for other than treatment, payment, or health care operations; however, the practice will not get an authorization for the use or disclosure of protected health information specifically allowed under the Privacy Rule in the absence of an authorization. The practice will provide a patient upon request a copy of any authorization initiated by the practice (as opposed to requested by the patient) and signed by the patient.

The practice does not condition treatment of a patient on the signing of an authorization, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of health care solely for purpose of creating protected health information for disclosure to a third party (e.g., pre-employment or life insurance physicals).

In Illinois, a specific written authorization is required to disclose or release of mental health treatment, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

The practice allows an individual to revoke an authorization at any time. The revocation must be in writing and must be sent to the attention of the practice's privacy officer, however, in any case the practice will be able to use or disclose the protected health information to the extent practice has taken action in reliance on the authorization.

Individual Rights – Waiver of Rights

The practice never requires an individual to waive any of his or her individual rights as a condition for the provision of treatment, except under very limited circumstances allowed under law.