

New Patient Demographics

Last Name: _____ First Name: _____ Middle: _____

Nickname/Preferred Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____ Suite/Apt/Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the number where we may leave a detailed, confidential message.

Email Address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

How were you referred to our office?

Patient (name): _____

Facility (full name): _____

Physician (first and last name): _____

Social Media (which platform): _____

Employer Information

Name: _____

City: _____ State: _____ Zip Code: _____

Position: _____ Status: Full-Time Part-Time

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Your insurance is necessary for us to process any insurance claims and to ensure payments of service rendered.

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Chicago Women's Health Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (Patient and/or guardian if minor): _____ Date: _____

New Patient History

Name: _____ Date: _____

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today? _____

What are your preferred gender pronouns?

- She, her, hers, herself
- He, him, his, himself
- They, them, theirs, themselves
- Ze, hir, hirs, himself
- Just my name, please
- Other: _____

What is your ethnicity/ancestry?

- Ashkenazi Jewish
- Asian
- Black/African American
- French Canadian
- Hispanic/Latinx
- Mediterranean
- Native American or Alaska Native
- Pacific Islander or Native Hawaiian
- Sephardic Jewish
- White/Caucasian
- Other: _____

What medications are you currently taking? (Please list each medication and your current dose.)

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

Do you have any of the following health problems?

- | | | | | | |
|---------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraines/Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Postpartum depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other: _____ | | |
| Thyroid issues | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Do you have allergies to any medications? Yes No

If yes, please list: _____

Obstetric & Gynecologic History

Date of your last menstrual period: _____

Do you have any concerns about your periods? _____

Do you use a method of contraception? Yes No

If yes, please indicate which type: _____

Do you have sex with men, women, or both? _____

Do you have a history of any sexually transmitted infections? Yes No

If yes, please indicate which ones: _____

Date of your last Pap smear: _____

Do you have a history of abnormal Pap smears? Yes No

Did you receive the HPV/Gardasil vaccine? Yes No

Date of your last mammogram: _____

Have you had an abnormal mammogram? Yes No

Have you had a breast biopsy or surgery? Yes No

Have you ever been pregnant? Yes No

Have you ever had any surgery? (Please list.)

Do you have a family history of any of the following? (If yes, please list which family member.)

- | | | | |
|---------------------|--|--------------------------|--|
| Breast cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | High cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Ovarian cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Uterine cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Colon cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Pancreatic cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | Thyroid disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| Melanoma | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | Bleeding disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ | Blood clotting disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |

Social History

Do you drink Alcohol? Yes No

If yes, how many drinks per week? ____

Have you ever felt the need to cut down on drinking? Yes No

Do you smoke cigarettes or vape? Yes No

If yes, how many per day? _____

Do you use marijuana? Yes No

Do you use any other recreational drugs? Yes No

If yes, please specify: _____

What is your occupation? _____

Do you exercise? Please specify how often and what type: _____

Are you currently:

- Single In a Relationship Engaged Married Divorced Widowed

Past Pregnancies/Deliveries

Date (month and year): _____

Weeks: _____

Length of labor: _____

Birth weight: _____

Type of delivery: C-section Vaginal delivery

Do you use anesthesia? Yes No

If yes, please indicate which type: _____

Place of delivery: _____

Did you experience complications? Yes No

If yes, please specify (bleeding, vacuum/forceps delivery, shoulder dystocia, *etc.*):

Date (month and year): _____

Weeks: _____

Length of labor: _____

Birth weight: _____

Type of delivery: C-section Vaginal delivery

Do you use anesthesia? Yes No

If yes, please indicate which type: _____

Place of delivery: _____

Did you experience complications? Yes No

If yes, please specify (bleeding, vacuum/forceps delivery, shoulder dystocia, *etc.*):

Date (month and year): _____

Weeks: _____

Length of labor: _____

Birth weight: _____

Type of delivery: C-section Vaginal delivery

Do you use anesthesia? Yes No

If yes, please indicate which type: _____

Place of delivery: _____

Did you experience complications? Yes No

If yes, please specify (bleeding, vacuum/forceps delivery, shoulder dystocia, *etc.*):

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself	<input type="radio"/> <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

add columns _____ + _____ + _____

Total Score _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	_____
Somewhat difficult	_____
Very difficult	_____
Extremely difficult	_____

Genetic Screening Questionnaire

Name: _____ Date: _____

Please answer the following questions to the best of your ability. Your healthcare provider will review the information given at your visit. Thank you.

Will you be 35 years or older when the baby is due? Yes No

Age of father/sperm donor of the child: _____

What is your ethnicity/ancestry?

- | | |
|---|--|
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Native American or Alaska Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander or Native Hawaiian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Sephardic Jewish |
| <input type="checkbox"/> French Canadian | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Hispanic/Latinx | Other: _____ |
| <input type="checkbox"/> Mediterranean | |

What is the ethnicity/ancestry of the father/sperm donor?

- | | |
|---|--|
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Native American or Alaska Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander or Native Hawaiian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Sephardic Jewish |
| <input type="checkbox"/> French Canadian | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Hispanic/Latinx | Other: _____ |
| <input type="checkbox"/> Mediterranean | |

Do you have any religious reasons that you cannot receive blood products/transfusions? Yes No

Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

- | | | |
|---|------------------------------|-----------------------------|
| • Neural tube defect, i.e., spina bifida
(myelomeningocele or open spine), anencephaly | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Congenital heart defect | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Down syndrome | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Tay-Sachs | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Canavan disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Sickle cell disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Hemophilia | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Muscular dystrophy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Cystic fibrosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Do you or the baby's father have any close relatives with Fragile X? Yes No

Do you or the baby's father have diabetes, metabolic syndrome, celiac disease, PKU, or any other disorder that prevents you from metabolizing food without assistance? Yes No

Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal disorder not listed above? Yes No

In this or any previous relationships, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes No

Have you ever had chicken pox? Yes No

Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as chlamydia, herpes, gonorrhea, syphilis? Yes No

Have you or the baby's father ever had a positive test for HIV or been exposed to AIDS? Yes No

Have you ever had or tested positive for tuberculosis? Yes No

Are you and the baby's father related (besides marriage)? Yes No

Have you or the baby's father ever had hepatitis? Yes No

Do you work in the healthcare field? Yes No

Do you have cats? Yes No

Do you garden? Yes No

Have you traveled outside the country during pregnancy? Yes No

Have you taken any prescribed medication, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? If yes, please list medication and dose. Yes No

Have you had any previous pregnancies with a different practice? Yes No

If yes: _____

Date of delivery: _____

How many weeks when deliver: _____

Vaginal or Caesarean section: _____

Weight of baby: _____

PATIENT FINANCIAL POLICY

Thank you for choosing Chicago Women's Health Group as your healthcare provider. Our primary mission is to provide our patients with outstanding medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

You will be asked to fill out a new patient information form at your first visit. Please notify our office at your follow-up visit(s) if any of the information has changed.

All self-pay services must be paid prior to your visit. Please see the billing department when you arrive for your appointment.

As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. All copayments must be paid at the time of your visit. If you are not prepared to pay your copay, your appointment may be rescheduled. Payment of your balance is expected within 30 days after your claim has been adjudicated by your insurance, unless payment arrangements have been made with our billing department. We accept cash, checks, Visa, MasterCard, Discover, and American Express. There is a \$40 fee for checks returned due to insufficient funds. If you do not understand your statement or have questions regarding your balance, please feel free to contact our billing department at 312-943-0282 option 3 for clarification.

ADDITIONAL NOTES

Appointments must be canceled or rescheduled at least 24 hours prior to your appointment time or you will be subject to a \$50 fee for doctor appointment and \$100 fee for ultrasound or physical therapy appointment. We have reserved an appointment time for you and most likely will not be able to fill it at the last minute.

If you have any questions regarding billing, please contact our billing department at 312-943-0282 option 3 from 8:00 a.m. to 4:00 p.m. Additionally, you are always welcome to stop by our office when you are here for an appointment. We are happy to assist you!

Signature: _____

Date: _____

OBSTETRIC ULTRASOUND POLICY

During your pregnancy, you will most likely have several ultrasounds. You are encouraged to discuss these scans with your doctor, who will be happy to explain the reason each scan will be important for you.

You will have your first ultrasound at your first prenatal visit to establish dates and to make sure that all looks normal with the pregnancy.

Your second one may be the Nuchal Translucency scan. This scan looks at your baby's neck and helps to assess the risk for Down Syndrome and other genetic problems in the baby. This scan is optional.

The next scan is at approximately 20 weeks. This is an anatomy scan. Our sonographers will look over your baby from head to toe to look for anything that may not be developing normally. Also done at this time is a scan to check the length of your cervix, which can indicate whether your cervix may not be competent to hold the baby to term.

Another ultrasound scan is usually done around 36 weeks to check the size of your baby and to make sure everything looks as it should.

The cost of ultrasound is \$400-500 per scan. These will be billed to your insurance carrier.

If you are having any health issues or problems with your pregnancy, additional scans may be needed.

Recently, we have found that insurance is limiting the number of ultrasounds that they will cover. While our ultrasounds are billed with the appropriate procedure and diagnosis codes, we are finding that insurance is occasionally denying coverage. Any ultrasound scans not covered by your insurance will be your responsibility.

Please sign below indicating that you have read and understand our ultrasound policy.

Thank you.

Chicago Women's Health Group

Patient's name: _____

Signature: _____

Date: _____

OBSTETRICAL BILLING POLICY

Thank you for choosing Chicago Women's Health Group as your healthcare provider. Our primary mission is to provide patients with the highest standard of obstetrical care. In order to ensure a clear understanding of financial responsibility, we require that all patients review our Obstetrical Billing Policy in full.

Your acknowledgement of this policy is a condition of care and an important part of our professional relationship. Please read the information provided, and then sign and date this form where indicated.

Should you have any questions regarding this policy, you may contact our billing department at (312) 943-0282, option 3, or speak with our billing department during one of your scheduled office visits.

Insurance and Your Obstetrical Care

Our practice will assist you in submitting charges for obstetrical care and delivery to your insurance carrier. Please note, however, that insurance benefits vary by plan, and it is your responsibility to be familiar with the terms of your own coverage.

If we provide your complete obstetrical care and delivery, we will submit a **global obstetrical fee** to your insurance after delivery: **\$5,500 for a vaginal delivery** or **\$6,000 for a cesarean delivery**. This fee includes:

- Up to 13 routine prenatal visits
- The physician's charges for delivery of your baby
- One routine postpartum visit

The following services are **not included** in the global fee and will be billed separately: your initial pregnancy visit, non-stress tests, vaccines, ultrasounds, laboratory tests, genetic tests, circumcision, and cord blood collection. These services are your financial responsibility if not covered by your insurance.

For patients without insurance or enrolled in an out-of-network plan, our current **self-pay global fees** are:

- **\$7,175 for vaginal delivery**
- **\$7,675 for cesarean delivery**

These self-pay fees include your initial pregnancy visit, up to 13 routine prenatal visits, ultrasounds, laboratory tests, the delivery of your baby, and your routine postpartum visit. Services not included are non-stress tests, vaccines, carrier screen, circumcision, and cord blood collection, which are billed separately in addition to the self-pay global fee.

Please also note:

- Visits unrelated to pregnancy (*e.g.*, urinary tract infection, sore throat) are billed separately.
- Antepartum hospital admissions are billed separately.
- If you change insurance plans during pregnancy, each service must be billed to the appropriate plan, and the global fee will no longer apply.
- Should your insurance not cover any of the prenatal visits due to their timely filing requirements, charges for these visits will become your responsibility.
- If you transfer to an out-of-network plan during pregnancy, you will be considered a **non-global, self-pay patient at that time**, and your entire self-pay delivery fee must be paid by the time of your next prenatal visit. Please meet with our billing department to review payment arrangements.
- Should you lose insurance coverage or have a lapse in coverage, the full self-pay global fee will, at that point, become due. The self-pay global fee will be between \$4,500 and \$7,175, depending on how far along in your pregnancy you are when the coverage ends or the lapse begins.
- Failure to pay the self-pay global fee by the prenatal visit directly following the lapse in your coverage could result in transfer of your care to another provider.
- Hospital charges are billed directly by the hospital and are not included in our fees. The hospital may also require a separate deposit.

This is important! Insurance coordination of benefits applies if you are covered by more than one policy. If you have insurance through your employer and are also covered under your spouse's plan, your employer-sponsored plan is your **primary insurance** and your spouse's plan is **secondary**. You must provide complete and accurate insurance information to avoid delays in claim processing. If insurance is not covering your prenatal care because you have provided incorrect insurance information, charges will become your responsibility.

Pre-Certification

It is your responsibility as the insured to notify your insurance of your pregnancy and anticipated delivery and to confirm that coverage is active under your plan. At the time of hospital admission, you, your partner, or your designated representative are required to contact your insurance company to obtain the necessary authorization for your admission and delivery.

Obstetrical Deposit

All patients with verified commercial insurance are required to pay a **delivery deposit** based on their insurance benefits. **The minimum deposit is \$600** and must be paid in full no later than the **24th week of pregnancy**.

- The deposit may be paid in one lump sum or through an approved payment plan.
- If you elect a payment plan, the first installment is due at your **second prenatal visit**, and the final installment must be paid by your **24th week**.
- Failure to pay the required deposit in full by the 24th week of pregnancy may result in a transfer of your care to another provider.

After the delivery, our office will submit charges for your obstetrical care and delivery to your insurance carrier. Your deposit will be applied toward any portion of charges not covered by insurance.

- If a balance remains after application of your deposit, you will be responsible for the outstanding amount.
- If your deposit results in an overpayment, the excess will be refunded to you.

Cancellation, Returned Check, and Payment Policy

- **Appointment cancellations:** Appointments must be canceled or rescheduled at least **24 hours in advance**. Failure to provide timely notice will result in a **\$50 late cancellation/no-show fee for doctor appointment** and **\$100 fee for ultrasound or physical therapy appointment**.
- **Returned checks:** A **\$40 fee** will be assessed for each returned check.
- **Outstanding balances:** All outstanding balances must be paid at the time of each visit. Failure to make payment may result in cancellation of your appointment unless a payment plan has been arranged with our billing department in advance.

Patient Responsibility

I acknowledge that certain routine or recommended services may not be considered medically necessary for my insurance carrier and therefore may not be covered under my policy. I consent to receiving any services that my healthcare provider deems necessary for my care and agree to be financially responsible for charges not covered by my insurance.

I have read, understand, and agree to the terms outlined in the **Obstetrics Billing Policy**. My signature below confirms my acceptance of these terms and my financial responsibility for all charges incurred.

Patient's name: _____

Signature: _____

Date: _____

HIPAA PRIVACY RULE

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearinghouses, and those healthcare providers that conduct certain healthcare transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The paragraph at the bottom of this page is an addendum to our notice of Privacy Practices (see Notice of Privacy Practices). Some exciting changes in the Electronic Health Record (EHR) system across the physician practices at Northwestern are taking place. The eventual plan is for all physician practices to be able to access all their patients' electronic records within the Northwestern physician system (e.g., your internist will be able to look into your lab results at your gynecologist's office and see that you had a Pap and it was normal).

Please read the paragraph below. If you wish your information to be accessible to your other doctors at Northwestern, please opt in to this program. Please feel free to ask should you have any questions.

This practice is using an Electronic Health Record (EHR) information system in coordination with Northwestern Memorial Hospital (NMH). The collection and use of all information through the EHR system is primarily for the purpose of treatment of patients by NMH, this medical practice, and other medical practices in a clinically integrated care setting. The information collected through the EHR system may include information regarding my diagnosis and treatment for mental health, developmental disabilities, HIV, AIDS, drug and alcohol abuse, genetic testing and counseling. The EHR system is not equipped to segregate such data from my other health information. All information collected through the EHR system may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and healthcare providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, which may include: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR system and any related database for any of the above activities.

Please check the appropriate box and print, sign, and date.

I have read the privacy practices and consent to sharing my information with Northwestern providers.

Signature: _____ Date: _____

I have read the privacy practices and DO NOT consent to sharing my information with Northwestern providers.

Signature: _____ Date: _____

CHICAGO WOMEN'S HEALTH GROUP AT NORTHWESTERN NOTICE OF PRIVACY PRACTICES

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.

A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide detailed Notice in writing of our privacy practices. We know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in this Notice.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called "Protected Health Information" or "PHI." This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. Note that the reference "you" as used in this Notice refers to our patient even though this notice may be delivered to a parent or guardian of a patient that is a minor.

We are required by law to:

- A.** Maintain the privacy of PHI about you
- B.** Give you this Notice of our legal duties and privacy practices with respect to PHI
- C.** Comply with the terms of our Notice of Privacy Practices that is currently in effect

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

A. Uses and Disclosures for Treatment, Payment, and Healthcare Operations.

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or healthcare operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Treatment: We may use and disclose PHI about you to provide, coordinate or manage your healthcare and related services. We may consult with other healthcare providers regarding your treatment and coordinate and manage your healthcare with others. For example, we may use and disclose PHI when you need a prescription, lab work, an x-ray, or other healthcare services. In addition, we may use and disclose PHI about you when referring you to another health provider. For example, if you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to any medications.

Payment: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are about to receive. For example, we may ask for payment approval from your health plan before we provide care or services. We may use and disclose PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose PHI to insurance companies providing you with additional coverage. We may disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us. We may also disclose PHI to another healthcare provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that healthcare provider, company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

Healthcare Operations: We may use and disclose PHI in performing business activities which are called healthcare operations. Healthcare operations include doing things that allow us to improve the quality of care we provide and to reduce healthcare costs. We may use and disclose PHI about you in the following healthcare operations: (i) reviewing and improving the quality, efficiency, and cost of care that we provide to our patients (for example, we may use PHI about you to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment we provide to others); (ii) reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you and other patients; (iii) providing training programs for students, trainees, healthcare providers, or non-healthcare professionals (for example, billing personnel) to help them practice or improve their skills; (iv) cooperating with various people who review our activities (for example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with the law and managing our business); (v) reviewing our activities and using or disclosing PHI in the event that we sell our practice to someone else or combine with another practice; and (vi) business management and general administrative activities of our practice, including

managing our activities related to complying with the HIPAA Privacy Rule and other legal requirements. If another healthcare provider, company, or health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain healthcare operations of that healthcare provider or company. For example, such healthcare operations may include:

reviewing and improving the quality, efficiency, and cost of care provided to you; reviewing and evaluating the skills, qualifications, and performance of healthcare providers; providing training programs for students, trainees, healthcare providers, or non-healthcare professionals; cooperating with the outside organizations that evaluate, certify, or license healthcare providers or staff in a particular field or specialty; and assisting with legal compliance activities of that healthcare provider or company. We may disclose PHI for the healthcare operations of an “organized healthcare arrangement” in which we participate. An example of an “organized healthcare arrangement” is the joint care provided by a hospital and the doctors who see patients at the hospital.

Communication from Our Office: We may contact you to remind you of appointments and to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

B. Other Uses and Disclosures We Can Make Unless You Object.

Individuals Involved in Your Care or Payment for Your Care: We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person’s involvement in your care or payment for your care. If you are present and able to object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests. For example, if you are brought into this office and are unable to communicate normally with your physician for some reason, we may find it is in your best interest to give your prescription and other medical supplies to the friend or relative who brought you in for treatment. We may also use and disclose PHI to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other things that contain PHI about you.

C. Other Uses and Disclosures We Can Make Without Your Written Authorization or Opportunity to Agree or Object.

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply.

Required by Law: We may use and disclose PHI as required by federal, state, or local law. Any disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities: (i) to prevent or control disease, injury, or disability; (ii) to report disease, injury, birth, or death; (iii) to report Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities; (iv) to locate and notify persons of recalls of products they may be using; (v) to notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or (vi) to report to your employer (with notice to you), under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to an oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the healthcare system, government healthcare programs, and compliance with certain laws.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery request, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: We may, if we deem it appropriate, disclose certain PHI to law enforcement officials for law enforcement purposes.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person or determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation or transplantation.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

To Avert a Serious Threat to Health or Safety: We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.

Specialized Government Functions: Under certain circumstances, we may disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.

Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Medical Emergency: We may use and disclose PHI in the case of a medical emergency, in the event you have not yet received a copy of this Notice at the time of such emergency treatment.

D. Other Uses and Disclosures of PHI Require Your Authorization.

All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and healthcare operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. We are not required to agree to your request. If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency.

To request restrictions, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); (3) to whom you want those restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. This practice is using an Electronic Health Record (EHR) information system in coordination with Northwestern Memorial Hospital (NMH). The collection and use of all information through the EHR system is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. All information collected through the EHR system may also be shared with and used by NMH and certain other hospitals, academic institutions, and healthcare providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR system and any related database and incorporating it into a data warehouse maintained by NMH. The EHR system is not equipped to segregate such data as mental health, HIV, drug and alcohol abuse, and genetic testing information.

The patient acknowledges that this practice is using an Electronic Health Record (EHR) information system in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR system is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting.