



## NOTICE OF HEALTH INFORMATION 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. EFFECTIVE IMMEDIATELY.**

### Introduction

**We understand that medical information about you and your health is personal.** We are committed to treating and using that protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information.

### Understanding Your Health Record/Information

Each time you visit us a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged with improving the health of this state.
- Source of data for our planning and marketing
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

### Your Health Information Rights

Although your health record is our physical property, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### Our Responsibilities

We are required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice.



- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

## For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer. The telephone number is (773) 545-6900.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

*Office for Civil Rights*  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201

## Examples of Disclosures for Treatment, Payment and Health Operations

*We will use your health information for treatment.*

**For example:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

*We will use your health information for payment.*

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health operations.*

**For example:** Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.



**Business associates:** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**Directory:** Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Funeral directors:** We may disclose health info to funeral directors consistent with applicable law to carry out their duties.

**Organ procurement organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fund raising:** We may contact you as part of a fund-raising effort.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

**Law enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

773-545-6900  
773-545-2220 FAX  
WWW.BJC-ACES.COM



4211 N. CICERO AVE.  
SUITE 200  
CHICAGO, IL 60641

## **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have been presented with a copy of the "Notice of Health Information Practices" detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (s) concerning the use of my personal medical information:

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I also understand that in order to file insurance benefits on my behalf, it will be necessary to release information regarding the medical treatment that I have received.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name Here: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient.

Witnessed by: \_\_\_\_\_ Relationship: \_\_\_\_\_



## PATIENT CONSENT TO THE USE & DISCLOSURE OF HEALTH INFO FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, \_\_\_\_\_, understand that as part of my health care, paper and/or electronic records are originated and maintained describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- Means of communication among the many health professionals who contribute to my care.
- Source of information for applying my diagnosis and surgical information to my bill.
- Means by which a third-party payer can verify that services billed were actually provided.
- Tool for routine healthcare operations such as assessing quality & reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that it is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the right is reserved to change this notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the notice be changed, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, in agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_  
\_\_\_\_\_

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **ACCEPT** **I DECLINE** the terms of this consent. (must circle one)

I **CONSENT** **I REFUSE** to be treated. (must circle one)

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

- [ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_
- [ ] Consent refused by patient, and treatment refused as permitted.
- [ ] Consent added to the patient's medical record on \_\_\_\_\_

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## PATIENT AGREEMENT FOR MEDICAL SERVICES

The undersigned hereby agrees to the following terms and conditions:

I know that I have a condition that requires medical treatment and/or hospitalization. I hereby authorize the customary examinations, tests & procedures performed for this condition & for the medical and nursing care, including pharmaceuticals ordered consistent with the patient's right to be informed, in my presence or in the presence of any other responsible adult representing me.

I authorize the release of any medical information necessary to process any insurance claims. I understand that I am financially responsible for all amounts due and will promptly supply all information requested to my insurance company. Insurance companies may sometimes attempt to discount the charges or pay less than the amount due. If this happens, I authorize billing and collection staff to negotiate with my insurance carrier to obtain the maximum allowable reimbursement. I understand that I am liable for my deductible and coinsurance and for the amount charged if not reimbursed by my insurance company. I hereby assign and transfer any insurance benefits due me for professional services. A photocopy of these assignments shall be valid as the original.

I agree to remit any checks I receive from my insurance company for payment of medical bills incurred by me.

I agree to pay for attorneys' fees and all court costs incurred therein, in the event that it becomes necessary to enforce payment of a delinquent account by turning it over to an attorney. Venue for said suit shall be in Cook County, IL.

I agree to examine any billing statements that I receive & within thirty days of the billing date and advise of any billing errors.

I have been advised of the charges relative to all procedures and I agree that these charges are reasonable.

I have read the above and agree to all conditions stated within.

Print name: \_\_\_\_\_

Patient's signature/Legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

Patients Name: \_\_\_\_\_

Parent's name if patient is a minor: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_

## IRREVOCABLE ASSIGNMENTS OF BENEFITS

I authorize testing and treatment. I also authorize the release any information concerning my medical condition to any person or entity necessary to process this claim and authorize and assign the right to bill and receive payment from my insurance company, attorney or any party who may become obligated to pay or any sums. I further authorize the endorsement of my name to any draft containing my name to which is entitled. I hereby direct my attorney to pay in full any outstanding Bill or Balance out of any settlement or other source of proceeds arising from these injuries immediately upon receipt of funds at the attorney's office. If any of those payments checks include my attorney's name, I direct my attorney to sign his name for the benefit of the medical provider herein. I understand that I am personally responsible for any uncollected or unpaid balance on my account including the annual deductible and also any non-covered services based upon the charge determination of my health insurance carrier(s). I also understand that a 33% collection fee, in addition to attorney's fees will be collected upon demand if submitted to our Collections Attorney

Patient Signature: \_\_\_\_\_

Policy Holder signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## MEDICATION CHECKLIST

**Patient's name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

Are you allergic to any medications?  Yes  No

If so, please specify:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List current medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## OSWESTRY FORM

**Cervical • Lumbar • Neck • Arm R L • Lower back • Leg R L**

**How bad is your pain today? 0 1 2 3 4 5 6 7 8 9 10**

Date of visit: \_\_\_\_\_ Date of endoscopic spine surgery: \_\_\_\_\_  
 Patient's name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

For how long have you had back pain? \_\_\_Years \_\_\_ Months \_\_\_Weeks

For how long have you had leg pain? \_\_\_Years \_\_\_ Months \_\_\_Weeks

*Please read:* This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in every day life. Please answer every question by marking only one box from each section (that which best applies to you). We realize that you may consider that two statements in anyone section relate to you, but please just mark the box which most closely describes your problem.

### Section 1 - Pain intensity

- I can tolerate pain without taking painkillers.
- The pain is bad, but I manage without taking painkillers.
- Painkillers give me complete relief from pain.
- Painkillers give me moderate relief from pain.
- Painkillers give me very little relief from pain.
- Painkillers have no effect on the pain, and I do not use them.

### Section 2 - Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help, but I can manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

### Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.

### Section 4 - Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 'h mile.
- Pain prevents me from walking more than 'l. mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### Section 5 - Sitting

- I can sit in any chair for as long as I like.
- I can only sit in my favorite chair for as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 'h hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### Section 6 - Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### Section 7 - Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets, I have less than 6 hours of sleep.
- Even when I take tablets, I have less than 4 hours of sleep.
- Even when I take tablets, I have less than 2 hours of sleep.
- Pain prevents me from sleeping at all.

### Section 8 - Sex life

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal, but it is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents me from having any sex life at all.
- I cannot lift or carry anything at all.

### Section 9 - Social life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life, apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life, and I do not go out as often.
- Pain has restricted my social life to being at my home.
- I have no social life because of pain.

### Section 10 - Traveling

- I can travel anywhere without having pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I can manage journeys over 2 hours.
- Pain restricts me to journeys less than 1 hour in duration,
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.



## NEW PATIENT INFORMATION FORM

Please fill in the following information as completely as possible.

### Guarantor • Responsible Party

Name	Today's Date	
Address		
Zip	City	State
Telephone	Marital Status	
Social Security #	Employer	
Date of Birth	E-mail	Advanced Directive: <input type="radio"/> Yes <input type="radio"/> No

### Patient • Relation to Guarantor Self Spouse Child Other

Last Name	First Name	MI	
Maiden Name	Social Security #		
Address			
Zip	City	State	
Telephone	Referring Physician		
Date of Birth	Age	Employer	
Marital Status	Sex	Work Phone	Cell Phone
Emergency Contact	Relation	Phone	
Student: <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Full-time <input type="radio"/> Part-time	Name of School	
Is today's visit the result of auto accident? <input type="radio"/> Yes <input type="radio"/> No	Work Injury? <input type="radio"/> Yes <input type="radio"/> No	Date	
Other Coverage			
Spouse Name	Employer	Phone	

### Insured Policy Holder • Primary

Ins Co Name	Policy #	
Address	Group #	
Employer		
Zip	City	State
Patient Relation to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other		
Policy Holder Name		
Address		
Zip	City	State
Telephone	Date of Birth	Sex
Employer		

### Insured Policy Holder • Secondary

Ins Co Name	Policy #	
Address	Group #	
Employer		
Zip	City	State
Patient Relation to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other		
Policy Holder Name		
Address		
Zip	City	State
Telephone	Date of Birth	Sex
Employer		

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly. I understand payment is due at time of service.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_