Maximize Life Minimize Pain
PAIN SPECIALISTS OF GREATER CHICAGO

PATIENT DEMOGRAPHIC FORM

ID#_____
LOC_____

DATE: _____

NAME: _____
(Last) (First) (Middle)

DATE OF BIRTH: _____SS#:_____ EMAIL: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

SEX: M____ F____ MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____

HOME TEL # (_____)_____ CELL #: (_____)_____CONTACT BY: CELL# ___HOME#____

REFERRED BY: (PLEASE CHECK ONE) PCP DR_____REFERRING DR_____FRIEND_____FAMILY_____INTERNET_____OTHER__

PCP -NAME_____TEL # (_____)_____ FAX # (_____)_____

REFERRING DR- NAME_____ TEL#(_____)_____FAX# (_____)_____

EMPLOYED BY: _____ORK # (_____) _____

EMPLOYER ADDRESS: _____ ____TEL#(_____)_____

EMERGENCY CONTACT: _____RELATIONSHIP:_____ TEL # (_____)_____

PRIMARY INSURANCE NAME: _____HMO_____ PPO _____

SUBSCRIBER : SELF____SPOUSE____ SPOUSE NAME_____DATE OF BIRTH_____

IF MINOR GUARANTOR NAME_____ RELATIONSHIP:_____

POLICY/ID#_____ GROUP #_____

SECONDARY INSURANCE NAME: _____HMO_____ PPO _____ID#_____

INJURY RELATED TO: WORK ____ AUTO ____ DATE OF INJURY: _____

IF RELATED TO WORKMANS COMPENSATION PLEASE COMPLETE ADDITIONAL FORM PROVIDED

IF RELATED TO AUTO PLEASE PROVIDE HEALTH INSURANCE INFORMATION ONLY!

WORKMAN'S COMPENSATION INSURANCE COMPANY

NAME: _____ADDRESS: _____

CLAIM#_____DATE OF INJURY_____ ADJUSTOR NAME: _____

TEL# (_____)_____ FAX# (_____)_____

ATTORNEY INFORMATION
NAME_____ADDRESS_____

TEL#(_____)_____

BY SIGNING BELOW, I CERTIFY ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARANTOR NAME IF MINOR(PRINT): _____

PATIENT SIGNATURE_____ DATE:_____

VERIFIED BY: PSGC EMPLOYEE NAME:_____DATE: _____

7055 High Grove Blvd, Burr Ridge, IL 60527
P (630) 371-9980 F (630) 371-1555

Patient ID: _____

Maximize Life Minimize Pain
PAIN SPECIALISTS
OF GREATER CHICAGO

Pain Specialists of Greater Chicago Receipt of Notice of Privacy Practices & Patient Information Authorization

I, _____, hereby acknowledge receipt of the PSGC, S.C. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

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

I authorize the methods of communication of my protected health information as indicated below. I understand that under the HIPAA guidelines my patient information is kept confidential unless I provide written authorization.

The following person(s) may inquire regarding a medical service or billing statement, pick up records and prescriptions, and take messages pertaining to my health information.

1. _____ Relationship _____
2. _____ Relationship _____

I authorize PSGC to leave a message or send information regarding my personal health history, such as test results, physician messages, insurance or billing information or appointment information. Please initial each line that you authorize:

_____ Telephone message
_____ with a person listed above
_____ Mail to: · Home · Office
_____ Fax to: · Home · Office Fax number: (____) _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)

Maximize Life Minimize Pain

PAIN SPECIALISTS OF GREATER CHICAGO

ID_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS FOR PAIN SPECIALISTS OF GREATER CHICAGO & CONSENT FOR TREATMENT:

I hereby authorize Pain Specialists of Greater Chicago and its employees and agents to release my medical records documenting my examination and treatment, for submitting claims and upon valid request to Insurance companies.

I hereby assign benefits for payments to be made directly to Pain Specialists of Greater Chicago by Insurance companies for any medical/surgical procedures performed . I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I agree to be financially responsible to Pain Specialists of Greater Chicago, for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility.

I understand and acknowledge that if Pain Specialists of Greater Chicago files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 30 days.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested by Insurance companies relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Pain Specialists of Greater Chicago, physicians. practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care

RIGHT TO REFUSE TREATMENT

I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options.

PRINT PATIENT NAME:_____

PATIENT (GUARANTOR) SIGNATURE:_____ **DATE:**_____

PAIN SPECIALISTS OF GREATER CHICAGO

7055 HIGH GROVE BLVD• SUITE 100 • BURR RIDGE, IL 60527

630-371-9980 •• 630-371-1555

Patient ID# _____

Maximize Life Minimize Pain

PAIN SPECIALISTS OF GREATER CHICAGO

SIGNATURE SHEET

Initial Below

_____ **1) I have read and agree to Pain Specialists of Greater Chicago Notice of Privacy Practices/ HIPAA policy. Policy #1**

_____ **2) I have read and agree to Pain Specialists of Greater Chicago Medication and Prescription/ Refill Policy. Policy #2**

_____ **3) I have read and agree to Pain Specialists of Greater Chicago Controlled Substance to Treat Chronic Pain Policy. Policy #3**

_____ **4) I have read and agree to Pain Specialists of Greater Chicago Consent to Treat with Opioids Policy. Policy #4**

***I will be using the following pharmacy for my prescriptions:**

Pharmacy Name _____ **Phone** _____

Signature_____**Date**_____

Print_____ **E-mail Address**_____

***Revised 01/03/18, 05/06/16, 3/13/17**

Maximize Life Minimize Pain
PAIN SPECIALISTS OF GREATER CHICAGO

7055 High Grove Blvd. Ste. 100 Burr Ridge, IL 60527

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ SS# _____

Address: _____

Date of Birth: _____ Phone: _____

I authorize the release of the following medical information to Pain Specialists of Greater Chicago:

_____	Physician Notes	_____	Radiology Imaging Reports
_____	EKG/ EMG Reports	_____	Admission/Discharge
_____	Surgical Reports	_____	Patient Insurance Information
_____	Any & All	_____	Other: _____

Document Date: From _____ To _____

From: _____

Phone: _____ Fax: _____

Address_____

Please Fax to: Medical Records
7055 High Grove Blvd Ste. 100
Burr Ridge, IL 60527
Phone 630-984-4799 Fax 877-295-7647

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

_____ _____

Pt. Signature *Date*

If the patient is a minor, subject to guardianship. I have signed my name below on behalf of the patient and myself.

_____ _____

Parent's, Legal Guardian's or Agents signature *Date*

rev 9/17

Patient ID:_____

PAIN SPECIALISTS OF GREATER CHICAGO

Scott E Glaser, M.D., D.A.B.I.P.P.
Ira J Goodman, M.D.

Maria Anderson APRN
Theresa K Scheerenberger APRN
Randi L Hahn APN
Marie Ann Korallus APRN

BENEFIT ASSIGNMENT POLICY

Given the constant changes to insurance company payment policies, the following in-office policies have been established to help us continue to provide the patient with the best quality of medical care. These policies are intended to assist the patient in receiving care and for greater understanding in all aspects of patient care. If you would like to discuss these office policies, please ask to speak with a member of our Billing Department.

PAYMENT IS DUE AT THE TIME OF SERVICE.
This includes co-pays, deductibles, co-insurance and non-covered charges.

a) **Co-pay must be paid at the time of visit.**
b) For the patient's convenience, the office accepts cash, Visa, Master Card, Discover, and American Express
NO CHECKS ACCEPTED
c) The patient is responsible for **all** NON-COVERED SERVICE CHARGES
d) **SELF PAY** patients must pay at **time of visit**
NEW PATIENT - $274.00. This includes the office visit fee of $147.00 and lab test fee of $127.00
ESTABLISHED PATIENT- Subsequent visit fees - $100 .00: Lab Test fees - $127.00 Expected at next appointment

ANY CHANGES to your DEMOGRAPHICS or INSURANCE must be brought to our attention, **BEFORE** the Doctor's visit. Failure to do so may result in the patient being **responsible in FULL for ANY & ALL charges** for services rendered. The **CORRECT** information is **CRITICAL** especially for proper billing of laboratory tests that may be required and ordered. If this information is incorrect or not current the patient will be responsible for the bill in its entirety.
Health Insurance/Plan ID cards must be current.

If you have medical insurance, as a courtesy to you we will try to speed up the processing of your claim by submitting claims to your insurance company. However, your insurance plan is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim. **If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient.** Our office will **not** enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible. If the patients' bill remains overdue greater than 90 days the following procedure will occur.

- Any outstanding balance after **90** days of the date of service will become Zero balance status and **cannot** carry a balance.
- All outstanding bills must be settled **prior** to receiving future care, unless **PRIOR** arrangements have been made.

Cancellations/Missed appointments - Failure to keep your appointment or failure to cancel your appointment within a **24 hour** notice to fill the time slot we have reserved for you will result in a penalty charge of **$50.00**, for an office visit and **$150.00** for procedures These fees are **NOT** covered by insurance and is the sole responsibility of the patient. You the patient will be billed and payment is expected before next appointment. Please have the courtesy and respect to call our office for all appointments that cannot be kept.
We work with you at every opportunity to provide you with the best quality health care.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: _____

Signature: _____ **Date:** _____

Verified by : PSGC Employee name: _____ **Date:** _____

Credit Card Authorization

Scott E. Glaser, M.D., D.A.B.I.P.P
Ira J. Goodman, M.D.

Maria Anderson, APRN
Theresa K. Scheerenberger, APRN
Randi L. Hahn, APN

I authorize Pain Specialist of Greater Chicago to charge the patient-responsible balance(s) to the following credit card/debit card. I, cardholder will present a current picture DL/State ID or last four digits of SS#.

Circle One: VISA MasterCard Discover Amex

Name on Credit Card: _____

Patient name if applicable: _____

Credit Card Number: _____

Exp. Date (mm/yy): _____ **Card Holder Phone #** _____

Credit Card Billing Address: Street Number: _____ **Zip Code:** _____

Card Holder: DL____ State ID____ Last four digits of SS # xxx-xx-_____

I, _____ **(card holder)** will notify Pain Specialist of Greater Chicago Billing Department 630.371.9980 (option 6 / option 1) when I no longer want my credit card/debit card charged for patient _____ **(patient name).**

Card Holder Signature: _____ **Date:** _____

Printed Name: _____

E-mail Address: (please provide if you would like an e-mail receipt):

_____

Patient Name: **Patient Date of Birth:**

Patient PSGC ID Number (office use only):

PAIN SPECIALIST OF GREATER CHICAGO
7055 High Grove Blvd.• Suite 100 • Burr Ridge, IL 60527
Phone: 630.371.9980 Option 3 •• Fax: 630.371.9983

Maximize Life Minimize Pain
PAIN SPECIALISTS OF GREATER CHICAGO

Pain Specialists of Greater Chicago 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.

Pain Specialists of Greater Chicago, S.C. (hereinafter PSGC) acts to maintain the privacy of protected health information, provide individuals with notice of our practice's legal duties and privacy practices with respect to protected health information as described in the Notice, and abide by the terms of the Notice currently in effect.

Provision of Notice: PSGC, S.C. 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 13, 2003.

PSGC, S.C. makes its Notice available to any member of the public to enable each prospective patient to evaluate our practice's privacy practices when making his or her decision regarding whether to seek treatment from our practice PSGC, S.C. 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 PSGC, S.C., the patient will be asked 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. PSGC, S.C. 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, PSGC, S.C. 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: PSGC, S.C. 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 the patient's 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 PSGC, S.C.'s privacy officer at the practice's address. The practice investigates each complaint and may, at its discretion; reply to the patient or to 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, IL 60601. Voice phone 312-886-2359, fax 312-886-1807, TDD 312-353-5693.

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

Contact Person: PSGC, S.C. has a Privacy Officer that serves as the contact person for all issues related to the Privacy Rule. **The Privacy Officers are Cassandra Aguilar and Evans Castor. If you have any questions about this Notice, please contact either of the above individuals at 630-371-9980 or at 7055 High Grove Blvd., #100, Burr Ridge, Il. 60527**

Uses and Disclosures of Protected Health Information
PSGC, S.C. reasonably ensures that the protected health information (PHI) it requests, uses, and discloses for any purpose is the minimum amount of HGI necessary for that purpose.;

PSGC, S.C. treats all qualified individuals as personal representatives of patients. PSGC, S.C. 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 situations of abuse, neglect, or endangerment.

PSGC, S.C. makes reasonable efforts to ensure that protected health information is used only by and disclosed only to individuals who have a right to the protected health information. Toward that end, the 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 PSGC, S.C. 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* include 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: PSGC, S.C. 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, PSGC, S.C. 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.

PSGC, S.C. 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, PSGC, S.C. uses and discloses information as required by law.

Uses and Disclosures Required by Law: PSGC, S.C. uses and discloses protected health information to appropriate individuals as required by law.

As required by law PSGC, S.C. 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.

PSGC, S.C. discloses protected health information regarding victims of abuse, neglect, or domestic violence. PSGC, S.C. discloses information about a minor child, 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 abuse of disabled adults.

PSGC, S.C. 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 unless 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: PSGC, S.C. 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, PSGC, S.C. 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 PSGC, S.C. discloses PHI for law enforcement purposes to law enforcement officials.

Uses and Disclosures Related to Decedents: PSGC, S.C. 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: PSGC, S.C. 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: PSGC, S.C. uses and discloses protected health information to public health and other authorities as required by law to avert a serious threat to health and safety.

Uses and Disclosures for Specialized Government Functions: PSGC, S.C. 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: PSGC, S.C. uses and discloses protected health information as appropriate to provide treatment in emergency situations. In those instances where PSGC, S.C. 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: PSGC, S.C. does not use or disclose any protected health information for marketing purposes. PSGC, S.C. *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, PSGC, S.C. will 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: PSGC, S.C. does not engage in any research activities that require it to use or disclose protected health information.

Other Uses and Disclosures: PSGC, S.C. 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 PSGC, S.C. 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 PSGC, S.C. and complete an appropriate written authorization.

Individual Rights

Individual Rights – Accounting for Disclosures of Protected Health Information

PSGC, S.C. 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.

PSGC, S.C. charges a reasonable fee for more frequent accounting requests. The charge will be $25.00. 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.

PSGC, S.C. 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 on 30-day extension is permitted.

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

Individual Rights – Inspect and Copy Protected Health Information PSGC, S.C. 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.

PSGC, S.C. reviews the request in a timely fashion and acts on a request for access generally within 30 days. PSGC, S.C. 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 as to whether or not the denial is reviewable. 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.

PSGC, S.C. 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, CT 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
PSGC, S.C. 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 PSGC, S.C. will act on a request for amendment no later than 60 days after receipt of such a request. If PSGC, S.C. 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 PSGC, S.C. denies the request in whole or in part, the practice provides the requestor with a written denial in a timely fashion. PSGC, S.C. 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. PSGC, S.C. limits the length of a statement of disagreement to one page.

PSGC, S.C. 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
PSGC, S.C. 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 need be stated.

PSGC, S.C. accommodates all reasonable requests. The reasonableness of a request is determined solely on the basis of the administrative difficulty of complying with the request. PSGC, S.C. 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.
PSGC, S.C. 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
PSGC, S.C. accepts all requests for restrictions of disclosures of protected health information. PSGC, S.C. 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
PSGC, S.C. obtains a written authorization for 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. Upon request, the practice will provide a patient a copy of any authorization initiated by the practice (as opposed to requested by the patient) and signed by the patient.

PSGC, S.C. 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 information concerning mental health treatment, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS).

PSGC, S.C. 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 the practice has taken action in reliance on the authorization.

Individual Rights- Waiver of Rights
PSGC, S.C. 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.

Maximize Life Minimize Pain

PAIN SPECIALISTS OF GREATER CHICAGO

POLICY FOR MEDICATION & PRESCRIPTIONS EFFECTIVE 04/28/15

SCHEDULE II MEDICATIONS (OPIOIDS/NARCOTICS)

- Patients must obtain written monthly prescriptions for Schedule II and III medications. By law these prescriptions cannot be renewed by phone or fax. In unusual circumstances, PSGC may allow you to designate an individual over the age of 21 who will pick up your prescription. This individual will need to present their photo ID.
- In an effort to ensure safety and efficacy, attempts will be made to consult with each patient at the time of their monthly prescription.
- IL state law states Schedule II medications are written for a 30-day supply only. Some insurance companies restrict amounts of medication. It is your responsibility to comply with their restrictions.
- 90 day mail-in prescriptions will not be written for any class of opioid medications without your MD's stated approval in advance.
- If your medication is changed mid prescription all efforts should be made to return any remaining medication to the PSGC medication nurse before a new prescription is released.
- As with doctor visits HMO/POS patients must obtain a referral for visits with the physician assistant for medication management as these visits are under the supervision of our doctors and subject to co-pays.
- All requests for EARLY MEDICATION RELEASES are tracked and reviewed by the caregivers at PSGC. Early releases must be authorized by the MD or other caregiver and an early release form filled out and signed by patient and nurse. This includes vacation releases. This must be done to adhere to federal law as it is a felony to lie to a caregiver to obtain controlled substances.

NON SCHEDULE MEDICATIONS (refills)

- Non-schedule medications may be refilled over the phone with your pharmacy.
- You or your PHARMACIST will need to call 3 business days before your refill is needed.
- Three-month mail-in for medications will be considered on a case-by-case-basis.
- All unusual early requests for refills will be documented and reviewed by your physician. **FAILURE TO FOLLOW THESE GUIDELINES OR MISUSE OF PRESCRIBED MEDICATIONS MAY RESULT IN THE INABILITY TO PRESCRIBE CONTROLLED SUBSTANCES ON AN ONGOING BASIS. IN SOME CASES, IT MAY LEAD TO DISCHARGE FROM PAIN SPECIALISTS OF GREATER CHICAGO.**

Maximize Life Minimize Pain
PAIN SPECIALISTS OF GREATER CHICAGO

PATIENT AGREEMENT BETWEEN PAIN SPECIALISTS OF GREATER CHICAGO AND PATIENTS WHO ARE PRESCRIBED CONTROLLED SUBSTANCES TO TREAT CHRONIC PAIN

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (NARCOTIC pain medications), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because it is not certain whether they are beneficial when used to treat chronic benign pain. Patients who are prescribed these drugs have some risk of developing an abusive relationship with the medication or suffering a relapse of a prior history of substance abuse. The extent of this risk is not certain. Additionally, these substances have a narrow therapeutic window and the risk of accidental over dosage and death is high.

Because of the risk that a patient may have a substance abuse disorder and because of the risk of diversion of these medications to those with substance abuse disorders it is necessary to observe strict rules when they are prescribed on a regular and continuous basis. For this reason we require each patient receiving long-term treatment with these medications to read, understand in full, and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your chronic pain.

1. All opioids used to treat my chronic pain must come from a caregiver in this office. My controlled substances will come from the caregiver whose signature appears below, or, during his or her absence, by another caregiver unless specific authorization is obtained for an exception. I will notify my caregivers of all medications used to treat other conditions prescribed by any other care providers.

2. I understand that my physician and his/her staff will access the Illinois Prescription Monitoring database for purposes of verifying that I am complying with the controlled substances policies of this office.

3. I will comply with any monitoring or restrictions that my physician requires.

4. I will inform my physician of any personal current or past substance abuse and any current or past substance abuse of any immediate member of my immediate family.

5. I will make an effort to obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform the PSGC office. The pharmacy I am seeing is:

6. I will inform the PSGC office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

7. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

8. I will not allow anyone else to have, use, sell, or otherwise have access to these medications.

9. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

10. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.

11. I understand that if I have medications left at the end of the month, I will notify the PSGC office so that my future prescriptions can be adjusted accordingly and so that the excess medications can be disposed of properly. I understand that I am not to "stockpile" my medications and that any excess medications or old prescriptions of controlled substances should be brought to the PSGC office for proper and documented disposal.

12. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.

13. I will cooperate with unannounced urine or serum toxicology screens as may be requested. I understand that any evidence of tampering with these screens will affect my ability to be treated with controlled substances.

14. I understand that the presence of unauthorized substances, the lack of presence of prescribed controlled substances, or the presence of any illicit substances on urine toxicology testing may prompt referral for assessment for a substance abuse disorder.

15. I understand that these drugs may be hazardous or lethal to other people and animals and that I must keep them secure.

16. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill.

17. I understand that if I request an early refill secondary to lost, damaged or stolen prescriptions more than once within a year this is considered "red flag." The consequences may include change or cessation of treatment with controlled substances, referral to an addiction specialist, urine testing and possibly discharge from the practice.

18. I understand that a prescription may be given early if the physician or the patient will be out of town or otherwise indisposed when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to appropriate date.

19. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substance administration.

20. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

21. I will make every effort to keep my scheduled appointments in order to receive medication renewals. I understand that regular and continuous monitoring is vital to my care and treatment while utilizing controlled substances and my failure to keep scheduled appointments may result in cessation of therapy with controlled substance prescribing by this physician.

22. I understand that no refills will be given at night or on weekends.

23. I understand that any medical treatment is initially a trial, and that continued treatment with opioid medications is contingent on whether my physician believes that the chosen treatment is improving my clinical status.

24. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, tolerance and withdrawal. I have been explained the risks of over dosage including the possibility of respiratory arrest and death. I understand that there is evidence of other risks as well including hormonal side effects and enhanced sensitivity to pain in some cases.

25. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accept all its terms.

26. I am aware that attempting to obtain a controlled substance under false pretenses is illegal. I am aware that this is a felony.

27. I understand that at no time am I to operate heavy machinery, including driving a car, while under the influence of these medications or any other medications that may alter my judgment. I understand that there is the possibility of severe civil or criminal penalties if this occurs.

PATIENT CONSENT FOR TREATMENT WITH OPIOIDS

The caregivers at the Pain Specialists of Greater Chicago do at times need to utilize opioid medications to control acute, subacute, and chronic pain. I understand that I may require such medications now or in the future to control my pain. I understand that this consent is intended to deepen my appreciation for the possible consequences and complications of this course of treatment.

By signing this document, I attest that I am aware that the single greatest risk of utilizing opioids is the risk of ***accidental poisoning*** and ***death***. I understand that misuse or abuse can be associated with accidental poisoning but I am also aware that this terminal complication may occur even when using the medications compliantly. I understand that these pain medications are unique in that there can be a very small difference between the dose that provides pain relief and the dose that causes ***accidental poisoning*** and ***death***.

By signing this document, I attest that I understand that the risk of accidental poisoning is increased as the strength and/or dosage of the opioid is increased. I understand that the risk of accidental poisoning is increased when opioids are prescribed in conjunction with other medications that can depress the central nervous system including muscle relaxants, medications for anxiety and depression, and other medications. I understand that I must make the caregivers at PSGC aware of any and all medications I am taking and any new ones that are prescribed to me during my treatment.

By signing this document, I attest that I understand the risk of accidental poisoning is increased if alcohol or illicit medications are taken in conjunction with the opioids. I understand that I must make the caregivers aware of any illicit drug use and that I will discontinue such use while being treated with opioids. If I cannot accomplish this on my own, I will make PSGC aware so that they can help me find appropriate medical help.

By signing this document, I attest to the fact that I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and possibly that the medicine will not provide complete pain relief.

While I am taking opioid medications I agree not to be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. I understand that such activities include, but are not limited to: operating a motor vehicle, operating other equipment, working in unprotected heights or being responsible for an individual who is unable to care for him or herself.

I understand that the mere detectable presence of opioids in my bloodstream by a blood or urine test may cause legal entanglements. I understand that there is currently no acceptable minimal legal amount that could protect me from possible prosecution or lawsuits. I understand that this may occur even though these medications are prescribed by a physician. I understand that the caregivers of PSGC cannot condone operating heavy machinery while opioids are in my bloodstream.

I am aware that psychological addiction is defined as the use of a medicine even if it causes harm, having craving for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction

is individually dependent and is much more common in a person who has a family or personal history of addiction. ***I agree to tell my doctor all information about my past use of recreational or illegal drugs and any excessive use of alcohol. I also agree to inform my doctor of any treatment I have had for alcohol or drug use and any incidents in my past in which medical providers have expressed concern over my use of alcohol, recreational drugs or prescribed medication. I also agree to inform my doctor of any drug use or excessive alcohol use in my family.***

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the medicines noted below, I will experience a medical condition known as withdrawal syndrome. This means I may have any or all of the following symptoms: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin) buprenorphine (Buprenex, Suboxone) and butorphanol (Stadol) may reverse the action of the medicine I am using for pain control. . I understand that taking any of these medications while I am taking my pain medications can cause symptoms like those of a severe flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell all doctors treating me that I am taking an opioid as my pain medicine and that I cannot take any of the medicines listed above.

I am aware that tolerance to analgesia means that after using opioid medications over time I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain however; it has been seen and may occur to me. If it occurs, increasing my dose of opioids may not help reduce pain but may cause unacceptable side effects. If I develop tolerance to opioids or if opioids do not seem to be helping my pain effectively I understand that my doctor may choose another form of treatment. I understand that the development of tolerance can lead to higher doses and strengths of opioid medications being required to control my pain. I understand that this increases the risk of accidental poisoning and overdosage.

(Males only) I am aware that chronic opioid use has been associated with my low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that I should carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, I acknowledge that birth defects can occur whether or not the mother is on medicines and that there is always a possibility that my child will have a birth defect while I am taking an opioid medication.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing on the signature page, I give my consent for the treatment of my pain with opioid medicines.