



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: _____

Patient ID: _____



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)



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# _____

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



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



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



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.

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BURR RIDGE, IL 60527
630-371-9980 • 630-371-1555

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.

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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.

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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.

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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.

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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.

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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.

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