Patient Name _____ SS# _____

Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

DOB _____/_____/_____ Preferred Language_____ Work Phone _____

Marital Status (Circle One) Married Single Divorced Separated Widowed

Employer _____

Address _____ City, State, Zip_____

Email Address _____ How Did Hear You Hear About Us? (Circle One)

Billboard Clipper Ad Family Friend Health Department Hospital (Rush-Copley, Valley West, Edward)

Insurance Company Internet Newspaper Postcard Radio Suburban Woman Phone Book Physician Other

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Co _____ Policy Holder _____

DOB of Policy Holder _____/_____/_____ Employer _____

ID# _____ Group # _____ Copay $_____

Secondary Insurance Co _____ Policy Holder _____

DOB of Policy Holder _____/_____/_____ Employer _____

ID# _____ Group # _____ Copay $_____

Primary Care Physician _____ Office Phone _____

RELEASE AND FINANCIAL CONSENT

I hereby authorize the physicians at **Aishling Obstetrics & Gynecology** and staff under their direction to release all medical information, including test results, regarding my condition and medical treatment, to my primary care physician and/or insurance company I understand that I am financially responsible for all medical charges, whether or not paid by insurance, and I hereby authorize that use of this signature on all insurance submission.

Patient's Signature _____ Date _____

Updated 5/5/16

Aishling
Obstetrics & Gynecology

ACKNOWLEDGEMENT OF RECEIPT

Authorization for Disclosure/Notice of Privacy Practices

Patient Name: _____

The above named patient acknowledges receipt of Aishling Obstetrics & Gynecology, S.C. Notice of Privacy Practices provides detailed information about how the practice may use and disclose a patient's confidential information.

The above named patient understands that the practice reserves the right to change the privacy practices that are described in the Notice. The patient also understands that a copy of any Revised Notice will be provided or made available to the patient.

Signature: _____ **Date:** _____

Relationship to patient: _____

NOTIFICATION OF TEST RESULTS

Please fill out this form which will detail how you would like our practice to disclose your personal information. It is the policy of our office to make available to you laboratory results, ultrasound and X-ray reports ordered by Aishling Obstetrics & Gynecology, S.C by phone or mail. If you have not heard from us in 14 days from the date of your test, please call our office.

Please check all acceptable options of notification of <u>NORMAL</u> test results:

_____ Patient
_____ Other:_____ Relationship: _____
_____ I would prefer to call you to obtain results.
_____ You may leave message on my answering machine or voice mail at the following # _____

<u>Authorization to discuss personal health information:</u>

In addition to myself, I authorize the staff at Aishling Obstetrics & Gynecology, S.C to discuss my personal health information, including *<u>abnormal</u>* test results with:

Name: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

<u>Authorization to dispense medication(s):</u>

I authorize _____ relationship. _____ to pick up my medication(s) or any correspondence from the office of Aishling Obstetrics & Gynecology, S.C.

*****Person authorized to pick up medication(s) must present a photo ID*****

<u>Authorization to discuss billing information:</u>

I authorize _____ relationship. _____ to discuss any billing information with the staff from my physician office or delegate from the billing service.

Please notify us of *<u>ANY CHANGES</u>* in the above.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY,
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you

Payment: We may use and disclose your health information to obtain payment for services we provide to you

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization

Required by Law: We may use or disclose your health information when we are required to do so by law

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmates or patients under certain circumstances

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions You may request that we provide copies in a format other than photocopies We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations (You must make your request in writing) Your request must specify the alternative means or location, and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U S Department of Health and Human Services We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request.

We support your right to the privacy of your health information We will not retaliate in any way if you choose to file a complaint with us or with the U S Department of Health and Human Services

Contact Officer: Maureen Conway

Address: 831 E. Sandhurst Drive
Sandwich, IL 60548
Telephone: 815-786-1088
Fax: 815-786-1314

654 W. Veteran's Parkway, Suite A
Yorkville, IL 60560
Telephone: 630-553-3588
Fax: 630-553-3525