ORC | Orthopaedic and Rehabilitation Centers

www.orcchicago.com

ORC North Location:
5616 N. Western Avenue | Chicago, Illinois 60659
Tel (773) 878-6233|Fax (773) 878-2688

ORC Wicker Park Location:
St. Elizabeth Professional Building Suite 510
1431 N. Western Avenue | Chicago, IL 60622
Tel (773) 633-5866 | Fax (312) 633-5867

NOTICE OF PRIVACY PRACTICE

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new right to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

We respect patient confidentiality and only release medical information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by: ***Orthopaedic & Rehabilitation Centers, S.C.***

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be internal quality assessment review.

Information disclosed Without Your Consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances.

- Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.
- Follow-Up Appointment/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- As Required by Law. This will include situations where we have a subpoena, court order or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

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- Coroners, Funeral Directors and Organ Donation. We may disclose medical information to a coroner or medical examiner and funeral directors for the purposes of carrying out their duties. When organs are donated sufficient information will be provided to the program as necessary to facilitate the organ or tissue donation.
- Governmental Requirement. We may disclose information to a health oversight agency for activities authorized by law, such audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
- Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information we may charge you a reasonable fee for copying and mailing your record.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices form this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

_____ _____

Patient Signature **Date**

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PATEINT CONSENT FORM

CONSENT TO THE USE AND DISCLOSURE OF MEDICAL INFORMATION FOR THREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

I consent to the use or disclosure of my medical information by *Orthopaedic & Rehabilitation Centers, S.C.* for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduct healthcare operation of the practice. I understand that treatment by the practice may be denied if I do not sign this consent.

I have been informed by ***Orthopaedic & Rehabilitation Centers, S.C.*** of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my heath information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that ***Orthopaedic & Rehabilitation Centers, S.C.*** has the right to change its **Notice of Privacy Practices** from time to time and that I may contact ***Orthopaedic & Rehabilitation Centers, S.C.*** at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing, **Orthopaedic & Rehabilitation Centers, S.C.** restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that **Orthopaedic & Rehabilitiation Ceneters, S.C.** is not required to agree to my requested restrictions, but if **Orthopaedic & Rehabilitiation Centers, S.C.** do agree they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except where **Orthopaedic & Rehabilitation Centers, S.C.** has already made disclosure in reliance on prior consent.

_____ _____

Patient or Authorized Person Signature **Relationship to Patient**

_____ _____

Witness Signature **Date**

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ASSIGNMENT OF BENEFITS

In consideration of your undertaking to render care, I agree to the following:

Release of Information:

You are authorized to release any information you deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your facility.

Right to Receive Payment:

I authorize and assign you, the medical provider and treating facility, the right to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay me any sums. I further authorize endorsement of my name to any draft containing my name to which you are legally entitled.

Assignment of Right to Sue:

In the event any insurance company, attorney, or other person obligated by contractual agreement to make payment to me for your services, refuses to make such payment upon demand by you, I hereby assign and transfer you the cause of action that exist in my favor against such company, attorney or person and authorize you to prosecute said action either in my name or your name and for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account. I also understand that a 33% collection fee, in addition to attorney fees will be collected upon demand.

Attorney Direction:

I hereby direct my attorney not to interfere with or claim any lien upon, any medical payment benefits to which I may be entitled from either my health insurance or medical, workmen's compensation or other payment sources. And if any said medical payment checks include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of the medical provider, and Medical Center herein.

_____	_____	_____	_____
PATIENT OR PARENT IF MINOR	**DATE**	**WITNESS**	**DATE**

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AUTHORIZATION/RESPONSIBILITY AGREEMENT

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to:

ORTHOPAEDIC AND REHABILITATION CENTERS, S.C.

A copy of this form can be considered as an original for insurance purposes

I hereby agree to pay my account as services are provided. I f for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time frame. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I also understand that if my account is referred to collection, **a 33% collection fee** will be added to my balance. In addition, I understand that I will be charged for all costs of collection and reasonable attorney fees.

_____ _____

Signature of Responsible Party **Date**

_____ _____

Witness **Date**