NORTHWEST FAMILY HEALTHCARE

Last Name:		First Name:	Middle Initial
Date of Birth:	GENDER M or F	SSN:	MARITAL STATUS:
Address:		PHONE:	
City:		State:	Zip Code:
Primary Insurance Co.		POLICY HOLDER_____ RELATIONSHIP_____ ADDRESS:	
Primary Insurance Numbers & Group		DOB:_____ SSN:_____	

RACE	ETHNICITY	PREFERED LANGUAGE
O American Indian or Alaska Native O ASIAN O BLACK OR AFRICAN AMERICAN O NATIVE HAWAIIAN O OTHER PACIFIC ISLANDER O WHITE SELECT ONE OR MORE IF APPLICABLE	O HISPANIC OR LATINO O NOT HISPANIC OR LATINO Meaningful Use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative, Northwest Family Healthcare is required to gather information for compliance with the Meaningful Use guidelines. Part of this information includes adding patients' Race, Ethnicity, and Preferred Language to our electronic medical record. The government requires we gather this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have addition questions please visit the Office of the National Coordinator for Health Information Technology at www.healthit.hhs.gov and search Meaningful Use.	O ENGLISH O SPANISH O HINDI O RUSSIAN O FRENCH O KOREAN Other_____

NAME OF EMPLOYER: _____ WORK PHONE NUMBER:	EMERGENCY CONTACT& DATE OF BIRTH: PREFERRED CONTACT: EMAIL, PHONE, OR TEXT PHONE NUMBER AND/OR EMAIL ADDRESS:	PHARMACY: (NAME, LOCATION, PHONE) _____ _____

REFERRED BY: _____

AUTO ACCIDENT:_YES OR NO (GIVE ADDITIONAL INFO IF YES)_____

WORKERS COMPENSATION:YES OR NO (GIVE ADDITIONAL INFO IF Yes)_____

I HEARBY CONSENT FOR Northwest Family Healthcare to provide me with medical treatment. I authorize the release of medical information contained in my chart to my, and or, the insured's insurance company, in order to process my bills. I authorize the use and disclosure of my private health information for the purpose of the treatment, payment and healthcare operations. I authorize payment from my, and of the insured's insurance company directly to Northwest Family Healthcare. Should my insurance company deny or not cover charges for my, I am financially responsible for the full amount of the bill. Should my account be referred to an outside collection agency, I agree to pay the collection fees. Please note you are responsible for checking with your insurance on any lab, x-ray, or outpatient service you have. We are not responsible for services rendered and not covered by your insurance.

Primary insurance claims will be filed on your behalf with correct insurance information
Please provide our office with a copy (front and back) of your insurance card
Supplementary/secondary carriers will be filed ONCE as a courtesy
All HMO/POS patients are required to have a referral from our office if you are in need of another physicians services

SIGNATURE AND DATE

Word: complete new pt

DR. CAROLINE CHOI, M.D.

HEALTH HISTORY FORM

Patient Name:_____ DOB: _____

Past medical history	Past surgical history	Social history (please specify how much/often)	Family History	
_____ _____ _____ _____ _____ Last Tetanus shot:_____ Chicken pox virus:_____ or Vaccination date:_____		Smoking:_____ Never: Past: Current: Drinking:_____ Drug use:_____ STD's:_____	Diagnosis	Member
Allergies to meds (which meds and what reaction) **Seasonal allergies**	**Pregnancy** Living children:_____ Miscarriage:_____ Abortions:_____	**Exercise** Days per week:_____ Length:_____	**Screenings Type/Date** Mammo:_____ Colonoscopy:_____ Bone Density:_____ Sleep Study:_____	

Medications: (please list below) Dose: How often:

Word: complete now pt

1. **Insurance / Proof of Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage. All patients must provide their insurance card(s) to the Patient Service Representative at the time of check-in.

2. **Referrals, Co-payments and Deductibles.** Referrals must be presented at the time of service. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. You appointment will be rescheduled if any of these items are not available at time of service.

3. **Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers.

4. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information or notify us of changes in insurance in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. **Prescription Refills/Renewals.** Please do not wait until your prescription runs out or has expired. Allow ***72 hours notice*** to review your refill or renewal request. Refill and/or renewal requests will only be processed ***Monday through Friday*** during normal business hours. Controlled drug substance prescriptions must be picked up in the office in which you are seen and will not be refilled after hours or on weekends.

7. Appointments. We want to be able to provide every patient with all the attention they require. Therefore, if you are not on time for your appointment and are late 15 minutes or more, it may be necessary to reschedule for another day. Please provide us with 24 hour notice if you will not be able to maintain your appointment. Without a call you will be charged a $25 no show fee for a 15 minute appointment and $50 for a 30 minute appointment.

I have read and understand the above and agree to abide by its guidelines.

_____ _____

Printed name **Signature and date**

Word: complete new pt

NORTHWEST FAMILY HEALTHCARE

CAROLINE CHOI, MD

ELECTRONIC MAIL COMMUNICATION CONSENT

We are now able to provide communication by electronic mail (email). By signing this form, you are authorizing us to communicate with you by e-mail regarding your private health information. This may include (but not be limited to) lave results, diagnostic test results, communications with your physician and with Northwest Family Healthcare staff.

We acknowledge that electronic messages can be misdirected or intercepted by unintended parties. Northwest Family Healthcare cannot and does not guarantee the confidentiality of messages transmitted via the Internet. We believe that we should communicate private health information with you via e-mail only if you agree and after you have considered these risks. Please understand that anyone having access to your e-mail account could read your private health information.

I, _____, understand the potential privacy risks of communicating with my physician's office via e-mail. I wish to receive communications from Northwest Family Healthcare via e-mail related to (but not limited to) diagnostic test results and other information regarding my healthcare and treatment. I acknowledge that tese4 communications may contain private health information. The e-mail address provided by me below is the only e-mail address for which I authorized use by Northwest Family Healthcare.

_____ _____

Name (Last) (First) (MI) Date of Birth

_____ _____

Signature (patient or legal guardian) Date

_____

E-mail address

Word: complete new pt

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE FORM

REFERENCED POLICY: NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: SEPTEMBER 1, 2005

I have received a copy of the Notice of Privacy Practices:

_____PAPER

Name of Patient: _____

Signature of Individual Acknowledging NPP_____

_____ Patient

_____Personal Representative

_____Healthcare Surrogate

Employee Witness _____ Date _____

This Medical Practice was unable to attain patient acknowledgement of the Notice of Privacy Practices. Please explain below circumstances of the patient's refusal to acknowledge the Notice of Privacy Practices in the section provided below.

Place this form in the medical record.

Word: complete new pt

Practice Name: Northwest Family HealthCare	**NOTICE OF PRIVACY PRACTICES FORM**
EFFECTIVE DATE: April 14, 2013	**REFERENCED POLICY:**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

Every visit to a physician or other healthcare provider creates a record that is kept electronically or in paper form. This record typically includes symptoms, examination notes, diagnoses, test results, and plans of treatment. This Notice of Privacy Practices is applicable to all of the records of your protected health information produced or maintained by this Medical Practice.

This Medical Practice is required by law to maintain the privacy of protected health information, give each patient our Notice of Privacy Practices, and follow the practices listed below. Additionally, this medical practice is required to revise this Notice of Privacy Practices following the Federal Privacy Standards and provide an internal complaint process for privacy issues.

REVISIONS TO THE NOTICES OF PRIVACY PRACTICES

The language of the Notice of Privacy Practices applies to all medical records containing your protected health information that is produced or maintained by or on behalf of this Medical Practice. We reserve the right to change our policies at any time. Changes will apply to medical information about you that we already have as well as any new information after the change takes place. Before we implement significant changes in our policies or privacy practices we will post our new notice. You are entitled to our Notice at any time upon request. You will be asked to acknowledge in writing your receipt of this Notice.

QUESTIONS and COMPLAINTS

If you have any questions about this Notice of Privacy Practices, please contact us using the information listed on the next page. If you believe the privacy rights related to your protected health information have been violated you have the right to file a complaint with the individual listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer will provide you the address upon request.

We support your right to protect the privacy of your medical 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.

USES and DISCLOSURES OF HEALTH INFORMATION

This Medical Practice may use and disclose medical information about you for several different purposes. Below find an example of each possible use or disclosure of your protected health information.

Appointment Reminders: This Medical Practice may use or disclose your protected health information to remind you that you have an appointment for healthcare services. Reminders may include written notifications distributed via the US Postal system, verbal telephone communications and/or messages, or electronic mail messages.

Treatment: This Medical Practice may use or disclose your protected health information to treat your medical condition. For example, we may ask you to submit yourself to a laboratory test and we may use the results to obtain a diagnosis. Additionally, this Medical Practice may disclose your medical information to other individuals that may assist in your medical care, such as hospitals, physicians, children, guardians, healthcare surrogates, parents, or a spouse. This practice may also use a sign-in sheet and call patient names in the office waiting room.

Payment: This Medical Practice may use and disclose your protected health information in order to bill and collect payment for the healthcare services provided to you from this office. We may disclose your medical information to another covered entity or health care provider for the payment activities of the entity that receives the information. For example, we may make contact with your health plan to verify your enrollment and your eligibility for benefits. A disclosure of certain information may also be required for any payments made by credit or debit card or any other electronic means.

Healthcare Operations: This Medical Practice may use and disclose your protected health information in connection to the business of healthcare, including performance improvement, quality of care assessment, and cost management. We may disclose your medical information to another covered entity for health care operations of the entity that receives the information in limited circumstances, if each entity either has or had a relationship to you.

Marketing: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may provide you information by a newsletter or in person or by way of products or services of nominal value. We may disclose your medical information to a business associate to assist us in these activities. Any marketing materials sent from this office will disclose whether the marketing materials are from this office, whether this office received compensation from a third party for the marketing materials, and permit you to opt out of receiving future marketing materials. If this office uses health information for direct marketing materials to certain categories of patients, this office has made a determination that the marketed product or service could be beneficial to the health of the identified patients and the materials will state the reason the patients have been targeted and the benefits of the healthcare product or service.

If you do not want to receive marketing materials from this office (other than face to face), please contact a representative of Practice Name.

Fundraising: This medical practice may use or disclose your protected health information as part of our fundraising activity. The only health information used or disclosed for fundraising will be your name, address and demographic information (address, zip code, phone number) and dates of treatment. We may disclose this information to a business associate to assist us in our fundraising activities. We will provide you, in any fundraising materials, a description of how you may opt out of receiving future fundraising communications.

FURTHER SITUATIONS WHICH HEALTH INFORMATION MAY BE USED and DISCLOSED

Required by Law. This Medical Practice may use or disclose medical information about you when required by law. This office is required by Federal law to disclose your protected health information to the U.S. Department of Health and Human Service upon request for purpose of determining whether this medical practice is in compliance with the Federal Privacy Standards. We may disclose your health information when authorized by worker's compensation or comparable laws.

This Medical Practice will not use or disclose or protected health information in any manner that would violate the following laws:

Illinois Nursing Home Care Act

Illinois Mental Health and Development Disabilities Confidentiality Act

Illinois Mental Health and Development Disabilities Code

Illinois Medical Practice Act

Illinois Aids Confidentiality Act

Illinois Medical Patient Rights Act

Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

Law Enforcement: This Medical Practice may disclose health information if a request is made by law enforcement officials. For example:

In connection to criminal conduct at this office

In an emergency situation, to report a crime, victims of a crime, and the description, location, or identity of the perpetrator

To identify a suspect, material witness, fugitive or missing person

Concerning a death believed to be the result of criminal activity; and

Regarding a crime victim in certain situations

Public Health Activities: This Medical Practice may disclose your health information for public health activities, including:

To alert a government agency regarding abuse or neglect of an adult patient. However, this office will only disclose this health information if the patient consents or if this office is required or authorized by law to disclose this information.

For the prevention or control disease, injury or disability,

To report child abuse or neglect;

To maintain vital records, such as births and deaths;

To report side-affects to drugs or defects with products or devices;

To advise a person regarding possible contact to a communicable disease;

To inform an individual regarding possible risk for spread or contracting a disease or condition;

To alert individuals if a product or device they have has been recalled;

To advise your employer under narrow circumstances associated principally to workplace injury, illness, or medical surveillance.

Abuse, Neglect, and Domestic Violence: This Medical Practice may disclose your protected health information to a government agency if we believe you are a victim of abuse, neglect, or domestic violence. If this office makes such a disclosure, we will inform you, except if there is a belief that informing you places you at further risk of additional harm.

Serious Threats to Health or Safety: This Medical Practice may use or disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others. Under this situation, this office will only disclose health information to an agency or authority able to help prevent the threat.

Specialized Government Functions: This Medial Practice may disclose your protected health information if you are a member of the U.S. or foreign military and if required by the appropriate military command authorities. Furthermore, this office may disclose your health information to federal officials for intelligence and national security activities required by law. Additionally, this office may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials.

PATIENT RIGHTS REGARDING HEALTH INFORMATION

Right to Request Restrictions: You have the right to request a restriction on the use and disclosure of your protected health information for purposes of treatment, payment, and health care operations. We are not required to grant any such request for restriction, but if the restrictions are granted they will be legally binding, except in certain circumstances. You must fill out a Health Information Restriction Request Form in order to make the restriction valid.

Right to Provide an Authorization for Uses and Disclosures: You have the right to give authorization for uses and disclosures that are not identified by this Notice of Privacy Practices or are not permitted by applicable law. The authorization will be obtained by you completing the Authorization for Other Uses and Disclosures Form. Any authorization may be revoked at any time in writing. Once an authorization has been revoked, this Medical Practice may not use or disclose your health information for the purposes detailed in the authorization.

Right to Confidential Communications: You have the right to request that this Medical Practice communicate with you by an alternate means or at an alternate location. For example, you may ask this medical practice to contact you by e-mail rather than by phone or traditional mail. This medical practice will accommodate reasonable requests. In order for the request for confidential communications to be valid you have to complete a Confidential Communication Request Form.

Right to Access Information: You have the right to see and copy your protected health information. This Medical Practice is not required to provide access for all editions and versions of your health information that this office holds, such as psychotherapy notes or records prepared in anticipation of a civil, criminal or administrative hearing. This Medical Practice is required to give you access to health information held in designated record sets for as long as the records are maintained by this office or our business associates. In order to gain access to your health information you must complete the Request to Access Health Information Form.

Right to a Paper Copy of the Notice of Privacy Practices: You have the right to a paper copy of the Notice of Privacy Practices. You may ask this Medical Practice to give you a copy at any time. If you first obtain the Notice of Privacy Practices electronically, you may still request this office send you a paper copy.

Right to Request Amendments to Health Information: You have the right to request an amendment to your protected health information if you believe it is incorrect or incomplete. A request for an amendment to your health information may be made for as long as the information is kept by this medical practice. This Medical Practice may deny your request for an amendment to your health information if this office did not create the information or if a determination is made that the disputed health information is accurate and complete. To obtain an amendment you must complete an Amendment of Health Information Request Form. If this Medical Practice accepts the amendment request, you will be informed and you must agree to have the amended health information shared with others. If this medical practice denies the requested amendment, you are allowed to submit a written statement disagreeing with the denial to which this office may prepare a rebuttal. All statements will be maintained with your medical record on file.

Right to Receive an Accounting of Disclosures: You have a right to an accounting of disclosures of your protected health information made for purposes other than for treatment, payment and healthcare operations and those disclosures you have authorized. If your health information is disclosed for multiple research purposes this medical practice will provide you with a description of the research for which your health information may have been disclosed and the researchers names and contact information. This Medical Practice may charge you for reasonable retrieval, report preparation and mailing costs incurred in responding to accounting requests in excess of the one free accounting report required by the Federal Privacy Standards. You will be advised in advance of the associated fees and given a chance to withdraw or amend a disclosure request.