



FINANCIAL/TREATMENT CONSENT
WHOLE HEALTH CENTER – LOMBARD

Please complete and sign for treatment. Thank you.

DATE: _____

Circle one:

CHIROPRACTIC ACUPUNCTURE & ORIENTAL MEDICINE NATUROPATHIC NUTRITION

MEDICAL RADIOLOGY FACULTY PRACTICE Doctor assigned: _____

PATIENT INFORMATION:

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

Address _____ Responsible party _____
(If different)

City _____ State _____ Zip _____

Soc. Security # _____ / _____ / _____ Home Phone (____) _____ - _____ Cell (____) _____ - _____

Primary contact number preferred _____ Work Phone (____) _____ - _____

Emergency Contact _____ Relationship _____ Phone (____) _____ - _____

How did you hear about us? Circle: Friend/Family Patient Health Screen/Fair Marathon

Circle one: INSURANCE SELF-PAY DISCOUNT PROGRAM (list program) _____

We are in network with Blue Cross Blue Shield of Illinois PPO and Medicare. Insurance is accepted for services rendered in the following departments only: Chiropractic, Faculty and Medical. Our Faculty practice physicians may be participating providers with additional insurance companies. All other insurances will be processed as “out of network” and payment is expected at the time services are rendered.

Insurance Company _____ Effective date _____

Member ID# _____ Group# _____

Policy holder name (if self, note self) _____ Policy holder's birthdate _____

Relationship to insured (circle one): SELF SPOUSE CHILD

STATEMENT OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT:

I understand that I am financially responsible for all services rendered to me or my dependent at NUHS. I hereby authorize NUHS or its successors to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf I understand that I am financially responsible for any remaining balance.

I further authorize my insurance company to direct payment to NUHS on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

Signature _____ Date _____ / _____ / _____

I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES POLICY. _____ Initial, please.

OFFICE USE ONLY: LOMBARD

PATIENT NUMBER _____

NEW RE-CHECK EXAM MASSAGE TX

Verified _____

MEDICARE ABN _____ HIPAA policy _____

Entered _____



Department of Diagnostic Imaging

Patient Name: _____

Address: _____

Phone: _____ Today's Date: _____

I, _____, authorize National University of Health Sciences to release my X-ray films to:

Doctor: _____

Address: _____

I understand the original X-rays will be given to my doctor. If I wish to have copies of these films, I will discuss this and make arrangements with him/her.

Signed: _____ Date: _____

Witness: _____

I, _____, hereby give my consent to National University of Health Sciences to X-ray my child or ward.

Signed: _____

Relationship: _____

Address: _____

Date: _____

Witness: _____



AUTHORIZATION TO USE CLINICAL RECORDS AND CASE HISTORIES IN TEACHING, RESEARCH AND PROFESSIONAL PUBLICATIONS

The National University of Health Sciences clinic is a resource for the training and education of students in the professional curriculum leading to the doctor of chiropractic degree.

The faculty and the staff of the clinic utilize case histories of patients in their teaching and research. These case histories serve as examples of the use of chiropractic to illustrate the need for and utilization of chiropractic techniques, and to develop methods and new applications of chiropractic. The case histories also serve to inform the profession through published articles of specific clinical problems and their resolution through chiropractic treatment.

All such use of clinical reports and case histories is done without identifying the patient. The only information concerning the patient that may be revealed is defining the individual's gender and age.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment that the clinic provides in any way.

If you give authorization, you may change your mind and request that we not use your information. This request must be in writing and will not affect any information used prior to your written request.

I, _____, do/do not (circle one) authorize National University of Health Sciences to use my clinical records in the form of case reports for teaching, research and professional publications and understand that my identity will remain confidential.

Signature _____

Date _____



Patient's Bill of Rights

These rights can be exercised on the patient's behalf by a designated surrogate or proxy decision-maker if the patient lacks decision-making capacity, is legally incompetent, or is a minor.

The patient has the right to considerate and respectful care.

The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current and understandable information concerning diagnosis, treatment and prognosis.

Patients have the right to know the identity of physicians, nurses, residents, interns, or other trainees. The patient also has the right to know the immediate and long term financial implications of treatment choices, insofar as they are known.

The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and clinic policy, and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the clinic provides or transfer to another health care provider. The clinic should notify patients of any policy that might affect patient choice within the institution.

The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker with the expectation that the clinic will honor the intent of that directive to the extent permitted by law.

The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.

The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the clinic, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the clinic will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in those records.

The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.

NUHS Whole Health Center – Lombard

200 East Roosevelt Road ☐ Lombard, Illinois 60148-4583 ☐ 630-629-9664



NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

*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.*

Uses and Disclosures

Here are some examples of how we are allowed to disclose your private health care information for treatment, payment or clinic operations.

1. Your health care provider or a staff member may disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2. Our insurance and billing staff may disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your health care provider and members of the practice staff may use your health information, examination and treatment records, and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your health care provider and member of the practice staff may use your name, address, telephone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.250 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Research

Our research team is considered part of our practice staff. This team may need information in your medical records for a research study. For example, they may need to know your medical diagnosis or know about allergies you may have. The team may also need to collect health information about you from other health care providers because the information may be important to the study. For example, the research team may need to get your lab test results from your doctor.

Selection for participation in a research study is based on very specific criteria. You will need to give additional authorization to participate. This authorization will tell you:

- Who will use, share and receive your personal information;
- What personal health information is needed for the research study;
- Why your personal health information will be used or shared;
- Your right to change your mind and cancel your authorization at any time; and
- Information on what happens if you do not sign the authorization form, and how long your information will be used or shared.

The HIPAA privacy rule permits us to communicate with you regarding your health care. We will notify you by phone if we have to change, alter or cancel your scheduled appointment. Appointments are considered part of our treatment. Authorization or permission to call is not required. HIPAA allows a message to be left on an answering machine, voice mail or with a third party. Information will be limited to no more than necessary.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care to you.

Other than the circumstances described in the preceding five examples, and in the section Uses and Disclosures of this document, any other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. There are two circumstances under which we will not be able to honor your revocation request:

1. If we already released your health information before we received your request to revoke your authorization. 164.508(b)(5)(i)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization, please write to us at:

National University of Health Sciences
Clinics Business Office
200 E. Roosevelt Road
Lombard, IL 60148

Your Right to Limit Uses or Disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions are binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right to Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health information to you in person at the time you receive services from us. We may also mail you information regarding your health or the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like information in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy Your Health Information

You have the right to inspect and/or copy your health care information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your Right to Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting use to make.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- Those disclosures made to you.
- Those disclosures necessary to maintain a directory of individuals in our facility or to individuals involved in your care.
- Those disclosures for national security or intelligence purposes.
- Those disclosures made to correctional officers or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide you the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to a Paper Copy of This Notice

If you have agreed to receive privacy notices by email, you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your Right to Complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to us at:

National University of Health Sciences
Clinics Business Office
200 E. Roosevelt Road
Lombard, IL 60148

Marketing

From time to time, our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. We may need to use your health information including your name, address, telephone number, and your clinical records for the purpose of marketing products or services to you. The authorization form you sign for this purpose contains the name of the organization and/or the products and services we are marketing.

You have the right to refuse to give us authorization to contact you for marketing purposes. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

Fund Raising

From time to time, our practice raises money for charitable causes. We may need to use your health information including your name, address, telephone number, and your clinical records to contact you to request your assistance with these fund raising efforts. The authorization form you sign for this purpose contains the name of the organization(s) for whom we are raising money.

You have the right to refuse to give us authorization to contact you for fund raising purposes. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you about fund raising efforts at any time. Our practice and staff will receive direct or indirect remuneration from our fund raising activities.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside organizations.

Contact Us

If you would like further information about our privacy policies and practices, please contact:

National University of Health Sciences
Clinics Business Office
200 E. Roosevelt Road
Lombard, IL 60148