



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 _____

PATIENT NAME: _____

Informed Consent

Informed consent for your Acupuncture and/or Oriental Medicine treatment is a process and dialogue with your practitioner about the goals, risks, and alternative treatment options, to allow you to participate in and make knowledgeable decisions about your Acupuncture and/or Oriental Medicine care. It is very important that you as the patient read this document in its entirety. As a patient it is essential that you knowingly participate in decisions concerning the nature and course of your Acupuncture and/or Oriental Medicine care. It is essential that you ask questions and receive sufficient information from your practitioner about the potential risks, proposed benefits, and alternatives to your proposed Acupuncture and/or Oriental Medicine plan. Please **DO NOT SIGN** this document until you've had the opportunity to ask questions about your care and fully understand the care to be rendered, as well as read this document in its entirety.

Acupuncture and/or Oriental Medicine Treatment

The Acupuncture and/or Oriental Medicine care you receive may include standard examination and testing procedures. These may include a physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, and others as allowed by law in this state.

In addition, your practitioner may utilize pulse or tongue diagnosis techniques.

Acupuncture involves the insertion of pre-sterilized, disposable needles through the skin into the underlying tissues of specific points on the surface of the body. Treatment within the scope of Acupuncture and/or Oriental Medicine may include, but is not limited to, acupuncture, acupressure, moxabustion (direct or indirect application of heat to acupuncture points or needles), cupping (cups made of glass or other materials placed on the skin with a vacuum created by heat or other device), electrical stimulation (use of electrical device to produce electrical stimulation on the acupuncture needles), tui-na (Chinese massage), *gua sha* (Chinese dermal friction technique), Chinese herbal medicine, bleeding, bleeding cupping, and nutritional counseling based on traditional Chinese medical theory. Herbs may be consumed or applied on the skin according to the instructions provided orally and in writing by your practitioner. It's your responsibility to notify your practitioner of any unanticipated or unpleasant effects associated with the consumption or application of these herbs.

Probability and Nature of Risks Inherent in Acupuncture and Oriental Medicine Treatment

As with any healthcare procedure, there are certain complications, which may arise during Acupuncture and/or Oriental Medicine.

Side Effects of Herbs

Most herbs have an exceptional safety record. Occasionally reported side effects include headaches, skin rashes, allergic reactions, and digestive symptoms. These side effects most often resolve rapidly if the herbal dosage is reduced or stopped.

Herb-Drug Interaction

Confirmed cases of interactions between herbs and drugs are rare. Nevertheless, some prescribed drugs can have interactions with herbs. It is your responsibility to fully disclose to your practitioner any medications, herbs, or supplements you are currently using, to allow your practitioner to choose appropriate herbal preparations, and provide adequate advice and information. It is also your responsibility to fully advise your practitioner immediately of any symptoms or change in condition potentially indicative of a side effect or herb-drug interaction, to allow your practitioner to alter your care appropriately.

Herbal Toxicity

Very rarely toxicity in response to herbal preparation can occur. The organs most vulnerable to toxic effects from herbs are the liver and kidney. It is your responsibility to fully report to your practitioner any history of liver or kidney disease or dysfunction before herbs are prescribed.

Acupuncture Risks

Rarely acupuncture may cause discomfort, pain, bruising, blistering, bleeding, localized infection at the procedure site, temporary skin discoloration, and aggravation of pre-existing conditions. There are reports indicating certain acupuncture points can negatively effect pregnancy including spontaneous miscarriage. It is your responsibility to inform your practitioner if you are, or suspect you are pregnant.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, pain killers, and others
- Hospitalization
- Surgery

If you choose to use any of the above-noted other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Risks and Dangers of Remaining Untreated

Remaining untreated may result in persistent or increasing pain or other symptomatology, increased loss of function, formation of adhesions contributing to a pain reaction further reducing mobility, or worsening of your condition. Over time if you choose to remain untreated, this may complicate future treatment, and make future treatment more difficult and less effective the longer treatment is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [] or have had read to me [] the above explanation of the Acupuncture and/or Oriental Medicine and related treatment. I have discussed goals, risks, and alternative treatment options with my practitioner _____ and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and alternatives involved in undergoing treatment, and hereby consent to any or all of the aforementioned Acupuncture and/or Oriental Medicine treatment referred to in this consent.

Dated: _____

Dated: _____

Patient's Name

Practitioner's Name

Signature

Signature

**Signature of Parent or Guardian
(if a minor)**



The items below may relate to your current condition. In the space in front of each item, place an **H** if you previously **HAD** the problem. Place a **P** if you **PRESENTLY** have the problem. Leave space blank if you **NEVER** had the problem.

Patient Name _____

File Number _____

Date _____

GENERAL

- 1. _____ Fever / Chills
- 2. _____ Night Sweats
- 3. _____ Spontaneous Sweats
- 4. _____ Loss of Sleep
- 5. _____ Fatigue
- 6. _____ Nervousness
- 7. _____ Weight Loss or Gain
- 8. _____ Allergies
- 9. _____ Bleeding Problem
- 10. _____ Diabetes
- 11. _____ Thyroid Diseases
- 12. _____ Cancer
- 13. _____ HIV Risk Factors
- 14. _____ Cold or Warm Extremities

HEENT

- 15. Ear
 - A. _____ Ringing
 - B. _____ Hearing Loss
 - C. _____ Itching / Pain
 - D. _____ Other(s)
- 16. Eye(s)
 - A. _____ Dryness
 - B. _____ Redness
 - C. _____ Itching / Pain
 - D. _____ Blurred Vision
 - E. _____ Double Vision
 - F. _____ Tearing
 - G. _____ Other(s)
- 17. Nose
 - A. _____ Bleeding
 - B. _____ Congestion
 - C. _____ Clear Runny Nose
 - D. _____ Yellowish Runny Nose
 - E. _____ Sinus Infection
 - F. _____ Loss of Smell
 - G. _____ Other(s)

18. Mouth

- A. _____ Dryness
- B. _____ Abnormal Taste
- C. _____ Sore / Pain
- D. _____ Ulcerations
- E. _____ Gum Bleeding
- F. _____ Bad Taste in Mouth
- G. _____ Other(s)

19. _____ Dental Problems

- 20. Throat
 - A. _____ Dryness
 - B. _____ Itching / Soreness / Pain
 - C. _____ Swelling
 - D. _____ Difficulty Swallowing
 - E. _____ Hoarseness
 - F. _____ Tonsillectomy

CHEST IN GENERAL

- 21. Chest
 - A. _____ Distension
 - B. _____ Congestion
 - C. _____ Pain
 - D. _____ Warm / Heat Sensation

22. Breast

- A. _____ Pulling Sensation
- B. _____ Pain
- C. _____ Distension in Part
- D. _____ Nodule
- E. _____ Discharge

23. Epigastric Area

- A. _____ Pulling Sensation
- B. _____ Pain
- C. _____ Warm / Heat
- D. _____ Cold

LUNG / RESPIRATORY

- 24. _____ Difficult Breathing
- 25. _____ Shortness of Breathing
- 26. _____ Cough
- 27. _____ Chronic Cough
- 28. _____ Spitting Phlegm
- 29. _____ Spitting Blood
- 30. _____ Wheezing / Asthma
- 31. _____ Pneumonia
- 32. _____ Bronchitis
- 33. _____ Tuberculosis
- 34. _____ Seasonal Allergies
- 35. _____ Lack of Perspiration
- 36. _____ Excessive Perspiration
- 37. _____ Other(s)

HEART / CARDIOVASCULAR

- 38. _____ Irregular Heartbeat
- 39. _____ High Blood Pressure
- 40. _____ Low Blood Pressure
- 41. _____ Pain Over Heart
- 42. _____ Palpitations
- 43. _____ Poor Circulation
- 44. _____ Dizziness
- 45. _____ Fainting Spells
- 46. _____ Previous Heart Trouble
- 47. _____ Ankle Swelling
- 48. _____ Varicose Veins
- 49. _____ Rheumatic Fever
- 50. _____ Stroke
- 51. _____ Other(s)

SP / ST / LV / GASTROINTESTINAL

- 52. Abdomen
 - A. _____ Swollen
 - B. _____ Distension or Gas
 - C. _____ Pain
 - D. _____ Belching
 - E. _____ Stinging
 - F. _____ Coldness
 - G. _____ Constriction
 - H. _____ Cramping
 - I. _____ Pulling Down Sensation
- 53. _____ Poor Appetite
- 54. _____ Excessive Appetite
- 55. _____ Poor Digestion
- 56. _____ Nausea
- 57. _____ Vomiting
- 58. _____ Vomiting Blood
- 59. _____ Acid Regurgitation
- 60. _____ Ulcer
- 61. _____ Black or Bloody Stools
- 62. _____ Hernia
- 63. Frequency of Bowel Movement
Every _____ Day(s) _____ Time(s)
- 64. _____ Diarrhea
- 65. _____ Loose Stool
- 66. _____ Constipation
- 67. _____ Hemorrhoids
- 68. _____ Appendicitis
- 69. _____ Liver Problems
- 70. _____ Gall Bladder Problems
- 71. _____ Jaundice
- 72. _____ Hypochondric Pain
- 73. _____ Other(s)

KD / GENITOURINARY

- 74. ____ Frequent Urination
- 75. ____ Excessive Urination
- 76. ____ Difficulty Starting Urine Flow
- 77. ____ Night Urination
- 78. ____ Painful Urination
- 79. ____ Inability to Hold Urine
- 80. ____ Blood in Urine
- 81. ____ Kidney Disease
- 82. ____ Urinary Tract Infection
- 83. ____ Sexually Transmitted Disease(s)
- 84. ____ Sexual Difficulties
- 85. ____ Other(s)

NEURO-MUSCULOSKELETAL

- 86. ____ Neck Stiffness / Pain
- 87. ____ Pain Between Shoulders
- 88. ____ Arm / Wrist / Hand Pain
- 89. ____ Cold Hands
- 90. ____ Warm Palms
- 91. ____ Middle Back Pain
- 92. ____ Low Back Pain
- 93. ____ Abnormal Spinal Curvature
- 94. ____ Sciatica
- 95. ____ Knee Pain
- 96. ____ Ankle Pain
- 97. ____ Foot Pain
- 99. ____ Cold Foot
- 100. ____ Warm Sole
- 101. ____ Arthritis
- 102. ____ Swollen Joints
- 103. ____ Painful Joints
- 104. ____ Muscle Aches /Soreness
- 105. ____ Muscle Weakness
- 106. ____ Numbness / Tingling
- 107. ____ Twitching
- 108. ____ Tremors
- 109. ____ Fainting
- 110. ____ Convulsions
- 111. ____ Epilepsy
- 112. ____ Other(s)

NEURO-EMOTIONAL

- 113. ____ Dizziness
- 114. ____ Mental Disorder
- 115. ____ Headache
- 116. ____ Anxiety
- 117. ____ Depression
- 118. ____ Irritability
- 119. ____ Sighing
- 120. ____ Hot Temper
- 121. ____ Fluctuation of Mental State
- 122. ____ Other(s)

SKIN

- 123. ____ Itching
- 124. ____ Rashes
- 125. ____ Bruising Easily
- 126. ____ Change in Mole(s)
- 127. ____ Skin Cancer
- 128. ____ Eczema
- 129. ____ Psoriasis
- 130. ____ Other(s)

WOMEN ONLY

- 131. Menstrual Cycle
 - A. Date Last Period Began

 - B. Date Last PAP Test

 - C. ____ Menstrual Pain
____ Before ____ During ____ After
 - D. ____ Excessive Flow
 - E. ____ Irregular Cycles
 - F. ____ Color
 - G. Clots
____ Yes ____ No
- 132. Breast
 - A. ____ Breast Lump or Pain
 - B. ____ Breast Discharge
 - C. Date Last Mammogram

- 133. ____ Live Births

- 134. ____ Miscarriage
- 135. ____ Vaginal Burning / Itching
- 136. ____ Hot Flashes

MEN ONLY

- 137. ____ Testicular Swelling / Pain
- 138. ____ Prostate Problems

ACCIDENTS / TRAUMA

- 139. ____ Motor Vehicle Accidents
- 140. ____ Other Trauma / Accidents

CHILDHOOD DISEASES

- 141. ____ Mumps
- 142. ____ Measles
- 143. ____ Chicken Pox

HOSPITALIZATION / SURGERIES

- 144. ____ List Dates and Reasons
(Use space below)

NUTRITIONAL STATUS

- 145. ____ Nutritional Status
- 146. ____ Nutritional Supplements
- 147. ____ Herbs / Botanicals

HABITS / OTHERS

- 148. ____ Smoking ____ Packs a Day
- 149. ____ Drinking
- 150. ____ Recreational Drug Use
- 151. ____ Exercise per Week

FAMILY HISTORY

- 152. ____ Diabetes
- 153. ____ Thyroid Disease / Goiter
- 154. ____ Tuberculosis
- 155. ____ Kidney Disease
- 156. ____ High Blood Pressure
- 157. ____ Heart Disease
- 158. ____ Cancer
- 159. ____ Muscle, Bone or Nerve Disease
- 160. ____ Other

List Dates and Reasons for Hospitalizations / Surgeries: _____

Current Medications (including name, dose, frequency, and reason): _____

Current Physician: Name _____

Date Last Seen ____ / ____ / ____

Previous Acupuncture Care: Name _____

Date Last Seen ____ / ____ / ____

**CLINICAL ACUPUNCTURE PROGRAM
PATIENT QUESTIONNAIRE &
CONSENT FORM**

Patient Name _____

File # _____

Date _____

1. Have you been on any medications during the last two (2) months? Yes No
If yes, what are (were) they and what dosage was taken? _____

2. Are you now, or have you ever been, on blood thinners? Yes No

3. Have you ever taken cortisone or other drugs for arthritis? Yes No

4. Do you bleed easily? Yes No

5. Do you have a pacemaker or other device that has been surgically implanted into your body?
 Yes No

6. Have you ever had hepatitis or has your skin ever turned yellow? Yes No

7. Do you faint easily? Yes No

Acupuncture is an oriental procedure that is still being researched and investigated in this country. Please read the following statements that relate to this procedure. This is to comply with the guidelines of the FDA.

1. I, the undersigned, hereby authorize and direct _____
(Attending Clinician) to administer or directly supervise the administration of
acupuncture, which involves the insertion of needles or staples at one or more points
in the body, or the application of heat to one or more points of the body by
moxibustion, common to the oriental forms of meridian therapy.
2. All my questions have been answered by the Attending Clinician prior to my first
treatment. I further understand that I may ask additional questions at any time on
future visits.
3. I understand that in no manner have I been warranted or guaranteed a beneficial
result from the acupuncture treatment.

I have read the above statements and I consent to the use of acupuncture and realize it is not the standard
treatment for my condition(s).

Patient's Signature

Attending Clinician Signature

Intern Signature and Number



**National
University**
Of Health Sciences

Allergies

MEDICATION LIST

Name _____

File # _____

DOB _____

Date _____

Prescription Medications (include name, dosage, frequency, duration)

Over-the-Counter Medications (include name, dosage, frequency, duration)

Supplements/Herbs/Homeopathics (include name, dosage, frequency, duration, brand, route of administration)



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