ASSOCIATED PHYSICIANS GROUP
PAIN MANAGEMENT & PHYSICAL THERAPY CENTER

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. 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 provide you with this Notice which describes our privacy practices and legal duties, as well as your rights concerning your health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect July 23, 2015, and will remain in effect until we replace it.

We may change our privacy practices, and/or this Notice, from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. The revised Notice will apply to all of your health information from and after the revised date. 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 WITHOUT WRITTEN AUTHORIZATION

A. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in this Notice. We also use your health information and share it with others, in electronic or other format, to help treat your condition, coordinate payment for that treatment, and run our business operations. The following are examples of situations where we do not need your written authorization to use your health information or share it with others:

Treatment: We may use your health information to provide treatment to you. We may disclose your health information to a physician or other health care provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review

of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Disclosures to Your Family or Friends Involved in Your Care: Unless you object, we may disclose your health information to a family member, friend, or other person identified by you as being involved in your treatment or payment for your health care. If you are not present to agree or object, we may exercise our professional judgment to determine whether the disclosure is in your best interest, and will limit such disclosures to information necessary to help with your treatment or with payment for your health care. We may also notify a family member, personal representative, or another person responsible for your care about your location or general condition. 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.

Business Associates: We may disclose your health information to a "business associate" that needs the information in order to perform a function or service for our business operations. We will do so only if the business associate signs an agreement to protect the privacy of your health information. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company.

Appointment Reminders, Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to provide you with appointment reminders (such as voicemail, postcards, letters, e-mail or other similar mobile device communications). We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services, such as disease awareness or case management that may be of interest to you.

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications.

B. Uses and Disclosures for the Public Need

We may use your health information and share it with others in order to comply with the law or meet important public needs described below.

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

Public Health Activities: We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability. Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, admin-

istrative or criminal investigations, proceedings, or actions. This includes those agencies that monitor programs such as Medicaid.

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.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

To Avert a Serious and Imminent Threat to Health or Safety: 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. If we do, we will only share your information with someone able to help prevent the threat.

Workers' Compensation: We may disclose your health information to the extent necessary to comply with workers' compensation or other programs established by law that provide benefits for work-related injuries or illness without regard to fraud.

National Security: We may disclose to authorized Federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors: In the event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example,

to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties, and to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under the law.

C. Completely De-Identified and Partially De-Identified Health Information

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

REQUIREMENT FOR WRITTEN AUTHORIZATION

We may use your health information for treatment, payment, health care operations or other purposes described in this Notice. You may also give us written authorization to use your health information or to disclose it to anyone for any purpose. We cannot use or disclose your health information for any reason except those described in this Notice unless you give us written authorization to do so. For example, we require your written authorization for uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of your health information. Marketing is a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. You may obtain a form to revoke your authorization by using the contact information listed at the end of this Notice. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

Access: You have the right to inspect or obtain copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you have the right to obtain a copy of your health information in the form and format you request if the information is readily producible in that format, or, if not, a mutually agreeable alternative format. You also have the right to direct us to send a copy of your health information to a third party you clearly designate. We may charge you a reasonable, cost-based fee to cover copy costs and postage. If you request a copy of your electronic health information, we will not charge you any more than our labor costs in preparing the materials. 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. We will ordinarily respond to your request within 30 days. If we need additional time to respond, we will let you know as soon as possible. If you are denied access to your health information, you are entitled to a review by a health care professional, designated by us, who was not involved in the decision to deny access. If access is ultimately denied, you will be entitled to a written explanation of the reasons for the denial.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years or such shorter time as you may specify. That accounting will not include certain disclosures, in accordance with federal law, including disclosures made for the purposes of treatment, payment, or health care operations. You may obtain a form to request a disclosure accounting by using the contact information listed at the end of this Notice. We will ordinarily respond to your request within 60 days. If we need additional time to respond, we will let you know as soon as possible. You will receive one disclosure accounting annually free of charge, but we may charge you a reasonable, cost-based fee for additional accountings within the same twelve-month period.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to do so, we will put these restrictions in place except in an emergency situation or as required by law. We do not need to agree to the restriction unless (i) the disclosure is for the purpose of carrying our payment or health care operations and is not otherwise required by law, and (ii) the health information relates only to a health care item or service that you or someone on your behalf has paid for out of pocket and in full. You have the right to revoke the restriction at any time. You may obtain a form to request additional restrictions by using the contact information at the end of this Notice.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You may obtain a form to request additional alternative communications by using the contact information at the end of this Notice. Your request must specify how or where you wish to be contacted, and provide a satisfactory explanation regarding how payments will be handled if we communicate with you through the alternative means or location you request.

Amendment of Health Information: If you believe we have health information about you that is incorrect or incomplete, you may request in writing an amendment to your health information. You may obtain a form to request an amendment by using the contact information at the end of this Notice. Your request must explain why the information should be amended. We will ordinarily respond to your request within 60 days. If we need additional time to respond, we will let you know as soon as possible. If we did not create your health information, if your health information is not part of our records, or if your health information is already accurate and complete, we can deny your request and notify you of our decision in writing. You can submit a statement that you disagree with our decision, which we can rebut. You have the right to request that your original request, our denial, your statement of disagreement, and our rebuttal be included in future disclosures of your health information.

Notification of Breach of Unsecured Health Information: We are required by law to maintain the privacy of your health information, and to provide you with this Notice containing our legal duties and privacy practices with respect to your protected health information. Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a

breach of your unencrypted health information, we will notify you of the breach.

Paper Notice: You have the right at any time to obtain a paper copy of this Notice, even if you receive this Notice electronically. You may make such a request by writing to the address provided at the end of this Notice.

OTHER SPECIFIC STATE LAW REQUIREMENTS

This Notice explains the rights you have with respect to your health information under federal law. Some states provide even greater rights, including more favorable access and amendment rights, as well as protection for particularly sensitive information. For instance, in Illinois we are not able to disclose HIV/AIDS related information without your consent unless that disclosure is pursuant to a court order, for care or treatment purposes, otherwise required by law or to a government agency involved in collecting relevant data. We must also obtain your consent before disclosing your genetic information except when such disclosure is pursuant to a court order or legal proceeding, to determine paternity or otherwise permitted or required under applicable law. In certain instances you also have the right to restrict disclosure of your mental health and alcohol and drug abuse information. To the extent the law in Illinois affords you greater rights than described in this Notice, we will comply with these laws.

CONTACT INFORMATION

If you have any questions about this Notice, you may contact our Privacy Officer. Jim Moore is a Certified HIPAA Professional and may be reached at 618.708.1500.

COMPLAINTS

If you are concerned that we may have violated your privacy rights or have any other complaints, you may complain to us using the contact information above. 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. If you choose to file a complaint, we will not retaliate or take action against you for your complaint.

APG
ASSOCIATED PHYSICIANS GROUP
PAIN MANAGEMENT & PHYSICAL THERAPY CENTER

Phone: 1-888-363-8333

Today's Date_____

Name_____DOB_____

Male Female Soc Sec #_____

Mailing Address_____

City, State, Zip_____Home Phone_____

Cell Phone_____Work Phone_____

APG provides the option of electronic statements. Please check the appropriate box & provide your email. GO GREEN

Allow electronic statements: ☐No ☐Yes Email_____

Employer_____Occupation_____

Address, City, State_____Is it ok to call you at work? ☐ Yes ☐ No

How did you hear about us? ☐Phone Book ☐Newspaper ☐Seminar ☐Internet

☐Referral ☐Other_____

If you were referred, by whom? _____

Do you currently have a chiropractic physician? ☐No ☐Yes If Yes, who?_____

Do you have a primary care physician? Y N whom?_____

Emergency Contact _____ Relationship _____ Phone _____

Can we speak to a family member or spouse about your medical care: ☐ Yes ☐No

Authorized person _____ Relationship_____

	Primary Insurance	Secondary Insurance
Insurance Company		
Claims Address		
City, State, Zip		
Policy/ID #		
Group #		
Insured Name		
Relation		
Insured SS #		
Insured DOB		
Insured Employer		

Is your visit as a result of Worker's Compensation Injury or Automobile Accident? Y N

Name of Insurance Company: _____
Claim Number: _____ Adjustor Name: _____
Adjustor Contact Phone #: _____ Date of Injury: _____

_____ _____

SIGNATURE DATE

Welcome to Associated Physicians Group

The following document will serve as a summary of your health history during your initial visit to the APG. Please complete all sections; sign and date all pages. If you need assistance in filling out these forms, please call our office at 1-888-363-8333.

Name_____Date_____

Medical History

Medical Conditions: *please list all major illnesses/conditions you have been diagnosed with.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries: *please list all surgeries & the month/year they were performed*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History

Do you smoke? ☐Y ☐N Packs/Day_____ If quit, how long _____ how much prior _____

Do you drink Alcohol? ☐Y ☐N Drinks/Day_____

Do you consume caffeine?☐Y ☐N What kind & how much _____

Do you use recreational drugs? ☐Y ☐N Which _____

Average Hours of sleep _____

Exercise (specific activities & frequency) _____

Have you recently traveled to any foreign countries? ☐Y ☐N If Yes, where? _____

Are you a victim of physical or sexual abuse? ☐Y ☐N

Are you currently involved in or planning a claim/lawsuit for:

Workman's Comp ☐Y ☐N Personal Injury/Insurance ☐Y ☐N Disability ☐Y ☐N

If Yes to any, do you have an attorney ☐Y ☐N if yes, whom_____

_____

SIGNATURE DATE

APG
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PAIN MANAGEMENT & PHYSICAL THERAPY CENTER

Phone: 1-888-363-8333

Name _____ **Date** _____

Current Medications: *(Please list all medications you are currently taking, prescription & over the counter)*

Name of medication & strength	# of doses per day

Allergies:

Medications:_____**Food:**_____ **Check all that apply:** ☐**Latex** ☐**IV Contrast Dye**

☐**Betadine/Iodine** ☐**Adhesive Tape**

Family History: *(Anyone in your immediate family: mother, father, siblings, children)*

*Heart Disease who*_____ *Epilepsy who*_____
*Hypertension who*_____ *Glaucoma who*_____
*Stroke who*_____ *Bleeding Disorders who*_____
*Cancer who*_____ *Kidney Disease who*_____
*Diabetes who*_____ *Thyroid Disease who*_____
Gastrointestinal Disease who _____ *Liver Disease who* _____
Lung Disease who _____ *Other who* _____
_____ _____

<u>Women Only:</u>

Can you become pregnant: ☐Y ☐N If not why: _____ Are you now pregnant? ☐Y ☐N

Date of last period_____Normal ☐Y ☐N

Date of last Mammogram _____ Date of last Pap Smear_____Normal ☐Y ☐N

_____
SIGNATURE DATE

Welcome to Associated Physicians Group

Name _____ **Date** _____

REVIEW OF SYSTEMS: (CHECK ANY SYMPTOMS YOU HAVE HAD *RECENTLY* OR *FREQUENTLY IN THE PAST*

CONSTITUTIONAL	☐fever ☐weight loss ☐unusual fatigue ☐night sweats ☐poor appetite
HEAD/EYES	☐headaches ☐blurry vision ☐eye pain ☐eye discharge ☐double vision ☐loss of vision
EAR/NOSE/THROAT	☐ear discharge ☐hearing loss ☐ringing in ears ☐loss of taste ☐loss of smell ☐runny nose ☐nasal congestion ☐frequent nose bleeds ☐sore throat
CARDIOVASCULAR	☐chest pain/pressure ☐shortness of breath ☐palpitations ☐inability to lie flat ☐passing out ☐varicose veins ☐leg cramps *with exercise* ☐ankle/leg swelling
PULMONARY	☐cough ☐bloody cough ☐increased sputum volume ☐green sputum ☐blue extremities
GASTROINTESTINAL	☐difficulty/pain with swallowing ☐heartburn ☐bowel changes ☐constipation ☐diarrhea ☐black or bloody stools ☐abdominal pain or bloating ☐excessive gas ☐frequent nausea ☐fecal incontinence
WOMEN'S HEALTH	☐breast lumps ☐nipple discharge ☐asymmetry of breasts ☐vaginal discharge ☐vaginal spotting/bleeding (other than normal menstruation) ☐difficult periods ☐vaginal sores/lesions ☐pain with intercourse ☐decreased libido ☐hot flashes
MEN'S HEALTH	☐difficulty getting/maintaining erections ☐penile sores/lesions ☐decreased libido ☐penile discharge ☐testicular mass ☐testicular pain ☐difficulty starting/maintaining urine stream
URINARY TRACT	☐frequent and/or excessive urination ☐painful urination ☐urinary incontinence ☐blood in urine ☐cloudy or dark urine ☐flank pain
MUSCULOSKELETAL	☐painful joints ☐swollen joints ☐difficulty with range of motion ☐muscle pain ☐fluid on joints
SKIN	☐sores ☐rash ☐lumps/bumps ☐skin tags ☐suspicious moles ☐lesions ☐pallor
NEUROLOGY	☐numbness ☐muscle weakness ☐tingling ☐difficulty walking ☐poor memory ☐poor coordination ☐confusion ☐seizures ☐tremors ☐paralysis
ENDOCRINE	☐excessive thirst ☐excessive hunger ☐cold intolerance ☐heat intolerance ☐swollen glands
PSYCHIATRIC	☐anxiety ☐depression ☐suicidal thoughts ☐homicidal thoughts ☐apathy
OTHER	

SIGNATURE DATE

APG Pain Management & Physical Therapy

Name_____ **DOB** _____ **Date** _____

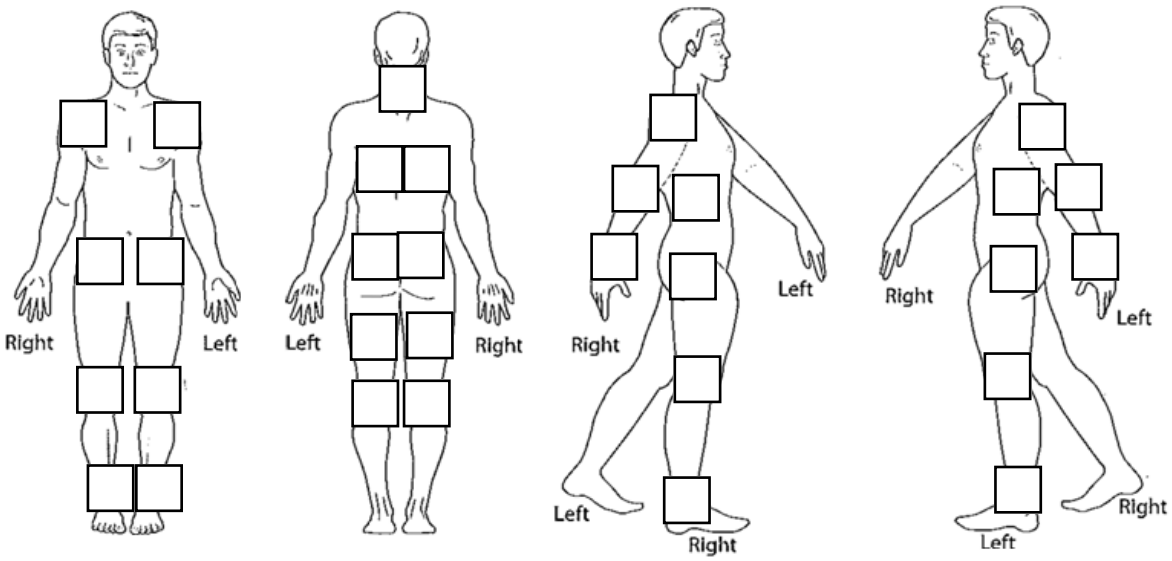
Previous Pain Treatments: *(Check all that apply)*

☐Injections/Nerve Blocks	☐Chiropractic Care	☐Massage/Acupressure	☐Pain Psychologist
☐Pain Clinic	☐TENS Unit	☐Acupuncture	☐Hypnosis
☐Physical Therapy	☐Deep Muscle Stimulation	☐Traction	☐Surgery

Previous Diagnostic Testing: *(Please list the date and place they were performed)*

Procedure	Date(s)	Body Part & Place Performed
X-Ray		
CT/MRI		
Ultrasound		
EMG/NCV		
Myelogram		
Other		

Please shade the areas on the diagram where your present pain is located *(please be careful to distinguish right from left)*



If "0" represents NO pain and "10" represents the WORST pain imaginable (i.e. childbirth or surgery without anesthesia), check the number that best describes the average pain you have had over the last 7 days

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please check all words that best describe your current pain:

☐Aching	☐Tight	☐Shooting	☐Constant	☐Severe
☐Throbbing	☐Cramping	☐Burning	☐Intermittent	☐Annoying
☐Dull	☐Sharp	☐Hot	☐Brief/Transient	☐Unbearable
☐Deep	☐Stinging	☐Cold	☐Mild	☐Excruciating
☐Sore	☐stabbing	☐Heavy	☐Moderate	

_____

SIGNATURE DATE

APG
ASSOCIATED PHYSICIANS GROUP

Cancellation Policy: Due to the high demand for appointments and in order to be respectful of the medical needs of all of our patients, it is necessary that a **24-hour notice of cancellation** be provided for any appointment that a patient is unable to attend. In the event the patient does not provide 24-hour notice, they will be charged a **$50 cancellation fee**. This will be billed directly to the patient and is not reimbursable by their insurance company. This fee will need to be paid before the patient will be seen for their next scheduled appointment.
If a patient fails to provide sufficient notification of cancellation for more than 2 appointments, we reserve the right to dismiss the patient from our care.

Driver Contract: Patients are instructed not to drive for 24 hours following spinal injections and certain other muscle, nerve or joint injections as there is a risk of numbness, weakness, light-headedness or other complication that may impair the patient's ability to drive or operate machinery safely and may lead to undue risk of accident, injury or death. This can occur at any time during the immediate 24 hours after an injection and is unpredictable, regardless of past experience with other injections, procedures or at other clinics.
By signing below, I indicate that I have been adequately informed of these risks and of my physician's requirement that I appear with a driver at the time of my procedure, for my own safety. My signature also indicates the understanding that, should I present without a driver, refuse to provide a driver, or choose to drive during the 24 hours following my procedure despite my physician's recommendations, that my procedure may be rescheduled or cancelled and that I may even be discharged from the practice on a case-by-case basis.

Privacy Policy (HIPAA): I have received or have been offered a copy and understand this practices Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duty in respect to my information. I understand that this practice reserves the right to change the terms of it's Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practice upon request.

Assignment of Benefits: I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Name: _____ Date: _____

Patient or Representative Signature: _____

Relationship: _____

ASSOCIATED PHYSICIANS GROUP
PAIN MANAGEMENT & PHYSICAL THERAPY CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE ASSOCIATED PHYSICIANS GROUP

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practice describes the uses and types of disclosures of my protected health information that might occur throughout my medical treatment, payment of bills or in the performance of Associated Physicians Group's health care operations. The Notice of Privacy Practice also describes my rights and Associated Physicians Group's duties with respect to my protected health information.

The Notice of Privacy Practice is available at Associated Physicians Group's office. Associated Physicians Group reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices upon a written or verbal request.

_____

Signature of Patient or Personal Representative

_____

Printed Patient Name or Personal Representative

_____

Date

_____

Description of Personal Representative's Relationship

ASSOCIATED PHYSICIANS GROUP
PAIN MANAGEMENT & PHYSICAL THERAPY CENTER

OFFICE POLICY OF ASSOCIATED PHYSICIANS GROUP

We want to give you information regarding our financial policy in order for us to provide the best service to you. Here are a few of the most common concerns.

1. REGARDING INSURANCE: The doctor's service is provided directly to you and not to an insurance company. If your insurance plan is a PPO plan or HMO plan, we will only collect your co-payment at the time of service. We are a Medicare provider, but without if you do not have a secondary supplement you will be responsible to 20% of your charges that Medicare does not pay. We cannot render service on the assumption that charges will be paid by the insurance company.

2. SPECIAL NEEDS: Special needs are understood by this office. It may be necessary to set up a payment plan for a patient requiring extensive treatment. To make payment arrangements, please call our Renee Carson in our billing department at 888.363.8333, extension 1100.

3. AUTHORIZATION: We do require your signature to authorize "release of information."
I hereby authorize Associated Physicians Group to release any medical information necessary to process charges, insurance forms, release medical records to other physicians or institutions upon request, and I also authorize payment directly to Associated Physicians Group, covering any benefits due for services rendered.

Signed_____Date_____

PROMISSORY STATEMENTS
"I hereby recognize and accept full responsibility for the timely payment of any balance remaining after such benefits have been paid." I have read the above office policy of Associated Physicians Group, and understand the financial policy of this office.

Signed_____Date_____
*We submit your surgical/hospital insurance as a service to you. Therefore, if you have any questions in this regard, please do not hesitate to contact us for assistance or clarification of your changes.

For co-pays and other payments our office will accept credit card, and check.

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Health Insurance Portability and Accountability Act (HIPPA)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care options.

As our patients, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it's appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and costing them money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate uses of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any services problems so that we may remedy the situation promptly.
Thank you for being one of our highly valued patients.

ASSOCIATED PHYSICIANS GROUP

Fax: □ (618)628-0883 □ (618)307-5950 □ (618)239-9795 □ (618)509-4870

Patient Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____ Telephone #: _____

Address:_____ City/State/ZipCode:_____

A. I request that my protected health information (PHI) **from** Associated Physicians Group to be disclosed **to**:

□ Self □ Name of Facility/Entity:_____ Attn:_____

Address:_____ City/State/Zip Code: _____

Phone:_____ Fax:_____

B. I request that my protected health information (PHI) be disclosed **to** Associated Physicians Group **from**:

Name of Facility/Entity:_____ Phone:_____ Fax:_____

Address:_____ City/State/Zip Code: _____

I authorize the following PHI to be released from my medical record:

_____Abstract/Summary (includes history, office notes, test results, consults)

_____Test results only

_____Other:_____

Covering the following dates of service: _____

I understand that the information in my medical record may include information relating to sensitive information.

State and federal laws protect this sensitive information. If the information applies to you, please check information to be released and initial. Provide date(s) if appropriate.

□ _____Alcohol, drug, or substance abuse records:

□ _____AIDS, HIV testing/results:

□ _____Mental health records:

□ _____Genetic records:

□ _____Research records:

□ _____Sexually Transmitted Disease records:

Purpose for requesting this information:

□ Legal □ Insurance

□ Personal □ Continuation of Care

Other: (please specify below)

_____

By signing this authorization form to disclose my medical records, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the applicable Associated Physicians Group office
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:_____. If I fail to specify an expiration date/event/condition, this authorization will expire 6 months from the date signed.
- Requests for copies of medical records may be subject to reproduction fees
- I understand that signing this authorization is voluntary.

_____ _____

Signature Patient or Authorized Representative Date

_____ _____

Print Name of Patient or Authorized Representative Relationship to Patient or Authority of Authorized Representative

Your life is digital.
Your bill can be, too.

Go Paperless

GO GREEN

Name_____ DOB_____ Male ☐ Female ☐

Mailing Address_____

City, State, Zip_____ Home Phone_____

Cell Phone_____ Work Phone_____

Email _____

I the undersigned hereby authorize Associated Physicians Group to send paperless statements to the above email address. By signing this, I understand that I will no longer receive paper statements in the mail. It is my responsibility to contact APG to advise of any change to my contact information, including my active email, that may impede me receiving these statements. This shall remain in effect until revoked by me in writing or through email contact.

_____

SIGNATURE DATE

APG
ASSOCIATED PHYSICIANS GROUP
PAIN MANAGEMENT & PHYSICAL THERAPY CENTER