PARK WEST
FAMILY MEDICINE

PATIENT INFORMATION

In order to serve you properly, we need the following information. All information will be confidential. Please print.

Patient name (Last, First Middle) _____ SSN _____

☐ Male ☐ Female Birth date_____ Home phone _____ Cell phone _____

Marital status: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Address _____ City _____ State ____ ZIP _____

Patient email:_____ Pharmacy No._____

RESPONSIBLE PARTY (Who is to receive the bills if other than self)

Name _____ Birth date _____ Phone _____

Address _____ City _____ State ____ ZIP _____

Employer _____ Work phone _____

Park West Family is not responsible to mediate any legal agreements regarding financial responsibility. Initial here _____

INSURANCE INFORMATION

Insurance company _____ ID# _____ Group# _____ Effective date _____

Name of insured _____ Relationship to patient _____

Birth date _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of insured _____ Relationship to patient _____

Birth date _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State ____ ZIP _____

PATIENT INFORMATION (Cont'd)

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable by me directly to the doctor.

_____ _____

Signature of patient or parent of minor Date

COMMUNICATION METHODS

We will use the minimum language necessary when disclosing your diagnosis on referrals, lab requests and mail-in prescriptions. May we contact you by telephone or mail as usual? If we leave a message on your telephone, it will be brief. For example, "Call doctor's office at (773) 929-7410." If you do not want us to use these methods, please state so below.

You request that we communicate with you about your health care in the following manner. Please check the appropriate boxes to instruct us of the method of relace we can use:

☐ In case of emergency, call _____ Relationship to patient _____

Home phone _____ Cell phone _____

☐ You may contact me by mail

☐ You may contact me by phone (Note: Caller ID may appear)

☐ You may release information about me to my friends and family whom I've listed below:

Full name _____ Phone number _____

Full name _____ Phone number _____

Full name _____ Phone number _____

Full name _____ Phone number _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have read and received the notice of privacy practices/HIPAA notice and rules.

_____ _____ _____

Signature of patient Print name Date

_____ _____ _____

Signature of parent/legal guardian Print name Date

_____ _____ _____

Signature of witness Print name Date

PARK WEST
FAMILY MEDICINE

CHILD HISTORY RECORD

To be filled out by parent or guardian

Today's date _____

Name _____ Age _____ Birth date_____

PREGNANCY AND BIRTH

Age of mother at baby's birth _____ Birth weight _____ Birth length _____

Infant's gestational age: ☐ Full-term ☐ Pre-term If pre-term, number of weeks: _____

Mother's blood type _____ Infant's blood type (if known) _____

Apgar scores (if known): _____ Mother Group B Strep status: _____

Type of delivery: ☐ Vaginal ☐ C-section If C-section, reason: _____

Initial feeding of baby: ☐ Breast ☐ Bottle

Obstetrician's name _____ City, State _____

Did mother use cigarettes, recreational drugs or medication during this pregnancy? ☐ Yes ☐ No

If yes, explain: _____

Were there any medical problems during pregnancy? ☐ Yes ☐ No
(i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor)

If yes, explain: _____

Were there any problems during labor? ☐ Yes ☐ No

If yes, explain: _____

Were there any problems during the nursery stay? ☐ Yes ☐ No
(i.e., jaundice, prematurity, feeding difficulties, breathing problems, infections)

If yes, explain: _____

Form continues on reverse side ...

2623 N. Halsted, Chicago, IL 60614 ■ 773 929 7410 ■ fax 773 929 7403 ■ info@parkwestfamilymedicine.com ■ parkwestfamilymedicine.com

CHILD HISTORY RECORD (Cont'd)

HOSPITALIZATIONS OR SERIOUS/UNUSUAL ILLNESSES

Identify any serious and/or unusual illnesses that your child has experienced and the corresponding date(s):

Date	Serious/unusual illness	Hospital/Physician's name	City, State

ALLERGIES

List allergies, including any allergic reactions to drugs _____

_____

FAMILY HISTORY

Check if the child or child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems:

	Child	*Family*		*Child*	*Family*
Frequent ear infections	☐	☐	Kidney / bladder problems or infections	☐	☐
Frequent colds / sore throats	☐	☐	Seizures / convulsions	☐	☐
Croup	☐	☐	Early heart disease (age 50 or younger)	☐	☐
Cystic fibrosis	☐	☐	High blood pressure	☐	☐
Wheezing / asthma	☐	☐	High cholesterol	☐	☐
Pneumonia	☐	☐	Lung disease / tuberculosis	☐	☐
Eye problems	☐	☐	Sexually transmitted diseases	☐	☐
Dental problems	☐	☐	Alcohol / drug abuse	☐	☐
Hearing problems	☐	☐	Emotional disorders / suicide attempts	☐	☐
Hay fever	☐	☐	Cancer	☐	☐
Eczema / skin problems	☐	☐	Unexplained childhood deaths	☐	☐
Anemia / blood problems	☐	☐	Other illnesses:		
Diabetes	☐	☐	_____		

CHILD HISTORY RECORD (Cont'd)

FAMILY HISTORY (Cont'd)

General health of imediate family members:

Mother's first name	Date of birth	Healthy	Problems (explain)
_____	_____	☐	☐ _____

Father's first name	Date of birth	Healthy	Problems (explain)
_____	_____	☐	☐ _____

Sibling's first names	Date of birth	Healthy	Problems (explain)
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____

Have any of the child's siblings died? ☐ No ☐ Yes (explain) _____

HEALTH AND SAFETY ISSUES

Are there any guns in the child's house?	☐ Yes	☐ No
Are the child's teeth brushed daily?	☐ Yes	☐ No
Does the child use a car seat or seat belt all the time?	☐ Yes	☐ No
Are there smoke detectors in the child's home?	☐ Yes	☐ No
Is the hot water temperature less than 125°?	☐ Yes	☐ No
Do you have rules/limits for television viewing?	☐ Yes	☐ No
Are medicines and potential poisons out of reach?	☐ Yes	☐ No
Do you have syrup of ipecac?	☐ Yes	☐ No
Do you know child resuscitation or choking management?	☐ Yes	☐ No

NOTICE OF PRIVACY PRACTICES-HIPAA

THIS NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PATIENTS FIRST: HOW WE PROTECT YOUR PRIVACY

At Park West Family Medicine, we are committed to providing you with the highest quality of care. An essential part of this commitment is our dedication to protecting the privacy and the confidentiality of your medical information.
Park West Family Medicine has coordinated its response to the new Privacy Practices and HIPAA regulations into one document which will be effective September 23rd 2013 at this location. Because the new regulations apply to all healthcare providers, ours is not the only notice you will receive. Though the format may vary, you will receive a notice from other healthcare entities providing care or service such as doctors, pharmacies, nursing homes and health care plans.
We encourage you to read the information contained in this handout in its entirety. It will explain how Park West Family Medicine may use and disclose your medical information and it will help you understand your rights as a patient.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer: Park West Family Medicine, 2623 N. Halsted, Chicago, IL 60614

Park West Family Medicine collects health information about you and stores it in a chart and on a computer under your chart number. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will need it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health care operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates" such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractor to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

1. Appointment reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

2. Sign-in sheet. We may use and disclose medical information about you by signing you in when you arrive at our office. We also will call your name when we are ready to see you.

3. Notification and communications with family. We may use and disclose health information to notify or assist in notifying member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of disaster, we may disclose information to a relief organization sot that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

4. Sale of health information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

5. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

6. Public health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

7. Health oversight activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

8. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or If your objections have been resolved by a court or administrative order.

9. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

10. Coroners. We may, and are sometimes required by law, to disclose your health information to coroners in connection with their investigations of deaths.

11. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

12. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

13. Proof of immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

14. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

15. Workers' compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

16. Change of ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

17. Breach notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associated may provide the notification. We may also provide notification by other methods as appropriate.

A. WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, Park West Family Medicine, consistent with its legal obligations, will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

B. YOUR HEALTH INFORMATION RIGHTS

Right to request special privacy protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

Right to request confidential communications. You have the right to request that your receive your health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to inspect and copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hard copy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing and explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Right to amend or supplement. You have the right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is

accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Right to not disclose to health plans. You have a right to request that physicians do not disclose information about the care you have paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law.

Right to an accountings of disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (Treatment), 2 (Payment), 3 (Health care operations), 6 (Notification and communication with family) and 18 (Specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to a Paper or Electronic Copy of this Notice. You have a right to receive a notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of the Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact our Privacy Officer listed on page 1 of this Notice of Privacy Practices.

C. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the term of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website, parkwestfamilymedicine.com

D. COMPLAINTS

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint and you will not be penalized in any way for doing so.

The form can be downloaded online at parkwestfamilymedicine.com/forms/

NOTICE OF PRIVACY PRACTICES

Effective date: _____

The privacy of your medical information is important to us at Park West Family Medicine. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

LAW REQUIRES US TO:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.

WE HAVE THE RIGHT TO:

1. Change the privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy and the new terms of our notice effective for all medical information that we keep, including previously created or received before the changes.
3. Before we make an important change in our policy, we will change this notice and make the new notice available upon request.

For treatment, we may use your medical information to provide you with medical treatment or services. We may disclose medical treatment about you to doctors, nurses, technicians, medical students or other people who are taking care of you.
For payment, we may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer.
Additional Uses and disclosures: In addition to using and disclosing your medical information for treatment, payment and operations, we may use your medical for the following purposes, abiding by all local, state and federal laws: Facility Directory, Notification, Disaster Relief, Research in Limited Circumstances, Funeral Director, Coroner Medical Examiner, Specialized Government, Functions, Court Orders and Judicial and Administrative Proceedings, Public Health Activities, Victims of Abuse, Neglect, or Domestic Violence, Workers Compensation, Health Oversight Activities, Law Enforcement, Appointment Reminders, Alternative and Additional Medical Services.

YOU HAVE THE RIGHT TO:

1. Look or get copies of certain parts of your medical information. You must make the request in writing, and there may or may not be a charge for this service.
2. Receive a list of times when your health information was shared other than for treatment, payment or operations and other specified exceptions.
3. Request that we put additional restrictions on our use of your medical information. We are not required to abide by these restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. This request must be in writing.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reason. If your request is denied, a written explanation will be provided. You may respond with a statement of disagreement that will be added to the information you want changed. If your request is accepted, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of information.
6. If you received this notice electronically and wish to receive paper copy, you have the right to obtain a paper copy by making a request in writing to this office.
7. A signed copy of this notice will be placed in your file and you have a right to request an additional copy for you records.

I fully understand my rights as stated in this agreement.

_____ _____

Signature of patient, legal guardian or representative | Date

_____ _____

Print name | Relationship to patient

FINANCIAL RESPONSIBILITY STATEMENT
CONSENT FOR TREATMENT

Please print

Patient's last name _____ First name _____ Middle initial ____

Guarantor's last name _____ First name _____ Middle initial ____

Your relationship to patient: ☐ Self ☐ Parent or legal guardian of minor ☐ Other (Please explain) _____

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of the medical services rendered by Park West Family Medicine physicians. You hereby assign, transfer and give to Park West Family Medicine, all your rights, title and interest in medical expense reimbursement benefits under any insurance policy, ERISA Plan, Medicare B benefits, or any other public or private health care benefit indemnification program or agreement otherwise payable to me for those services rendered by Park West Family Medicine. This agreement specifically includes, but is not limited to, an assignment of the rights to designate a beneficiary, add dependent eligibility, obtain payment of any auto or third-party liability policy benefits due for this treatment and to have individual or group converted or continued in accordance with its terms and benefits. As a patient, you may receive separate bills for services provided by outside laboratories that our providers utilize for further testing that is not provided by Park West Family Medicine. Any questions that you have about your insurance coverage or benefits should be directed to your health care plan and or certificate of coverage.

GUARANTEE OF PAYMENT

If your medical insurance coverage is not sufficient to satisfy the charges in full, you acknowledge that the resulting balance is not covered by the assignment and you will be fully responsible for the payment of the balance due upon discharge as consideration for medical services rendered. You agree to pay the established rates of Park West Family Medicine to facilitate collection of any self pay account balance and agree to pay the same. In the event that it should become necessary to resort to outside collection procedures, Park West Family Medicine reserves the right to charge the patient the collection costs and reasonable attorney's fee.

The undersigned certifies that he/she has read and understands the foregoing and is the patient or is duty authorized to accept the above terms on the patient's behalf.

_____ _____

Signature of patient or personal representative Date

CONSENT FOR TREATMENT

I wish to be treated and my permission is hereby given to Park West Family Medicine, its professional and clinical staff to administer any diagnostic or therapeutic treatment including the administration of any anesthetic as well as the performance of any procedure as may be deemed necessary or advisable in the treatment of myself or the minor child I am representing as a patient of Park West Family Medicine. I understand my physician will explain to me the nature of my condition, recommended treatment, associated risk involved as well as other ways this condition could be treated. No guarantees have been made to me about the outcome of this care.

_____ _____

Signature of patient or personal representative Date

_____ _____

Print name If personal representative, indicate relationship