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New Patient Demographics

Last Name: _____ First Name: _____ Middle: _____

Nickname/Preferred Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the number where we may leave a detailed, confidential message.

Email Address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

How were you referred to our office?

Patient (name): _____

Facility (full name): _____

Physician (first and last name): _____

Social media (which platform): _____

Employer Information

Name: _____

City: _____ State:_____ Zip Code: _____

Position: _____ Status: Full-Time ☐ Part-Time ☐

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Your insurance is necessary for us to process any insurance claims and to ensure payments of service rendered.

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Chicago Women's Health Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (Patient and/or guardian if minor): _____ Date: _____

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New Patient History

Name: _____ Date: _____

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today?_____

What are your gender pronouns?

- She, her, hers, herself
- He, him, his, himself
- They, them, theirs, themselves
- Just my name, please
- Other _____

What is your ethnicity/ancestry?

- Ashkenazi Jewish
- Asian
- Black/African American
- French Canadian
- Hispanic/Latinx
- Mediterranean
- Native American or Alaska Native
- Pacific Islander or Native Hawaiian
- Sephardic Jewish
- White/Caucasian
- Other _____

What medications are you currently taking? (Please list each medication and your current dose.)

1. _____
2. _____
3. _____
4. _____

Do you have any of the following health problems?

Asthma	☐ Yes	☐ No	Migraines/Headaches	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Postpartum depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Other: _____		
Thyroid issues	☐ Yes	☐ No			

Do you have allergies to any medications? ☐ Yes ☐ No

If yes, please list _____

Have you ever had surgery? (If yes, please list.)

1. _____
2. _____
3. _____
4. _____

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Do you have a family history of any of the following? (If yes, please list which family member)

Breast cancer	☐ Yes	☐ No _____	High cholesterol	☐ Yes	☐ No _____
Ovarian cancer	☐ Yes	☐ No _____	Heart disease	☐ Yes	☐ No _____
Uterine cancer	☐ Yes	☐ No _____	Diabetes	☐ Yes	☐ No _____
Colon cancer	☐ Yes	☐ No _____	Stroke	☐ Yes	☐ No _____
Pancreatic cancer	☐ Yes	☐ No _____	Thyroid disorders	☐ Yes	☐ No _____
Melanoma	☐ Yes	☐ No _____	Bleeding disorders	☐ Yes	☐ No _____
High blood pressure	☐ Yes	☐ No _____	Blood clotting disorders	☐ Yes	☐ No _____

Social History

Do you drink Alcohol? Yes ☐ No ☐
If yes, how many drinks per week? ____
Have you ever felt the need to cut down on drinking? Yes ☐ No ☐

Do you smoke Cigarettes or Vape? Yes ☐ No ☐
If yes, how many per day? _____

Do you use marijuana? Yes ☐ No ☐

Do you use any other recreational drugs? Yes ☐ No ☐
If yes, please specify _____

What is your occupation?_____

Do you exercise? Please specify how often and what type: _____

Are you currently:

Single ☐ In a Relationship ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐

Obstetric & Gynecologic History

Date of your last menstrual period _____

Do you have any concerns about your periods? _____

Do you use a method of contraception? Yes ☐ No ☐
If yes, please indicate which type: _____

Do you have sex with men, women, or both? _____

Do you have a history of any sexually transmitted infections? Yes ☐ No ☐
If yes, please indicate which ones: _____

Date of your last Pap Smear _____

Do you have a history of abnormal pap smears? Yes ☐ No ☐

Did you receive the HPV / Gardasil vaccine? Yes ☐ No ☐

Date of your last mammogram _____

Have you had an abnormal mammogram? Yes ☐ No ☐

Have you had a breast biopsy or surgery? Yes ☐ No ☐

Have you ever been pregnant? Yes ☐ No ☐

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Genetic Screening Questionnaire

Name: _____ Date: _____

Instructions: Please answer the following questions to the best of your ability. Your healthcare provider will review the information given at your visit. Thank you.

1. Will you be 35 years or older when the baby is due? ☐ Yes ☐ No

2. Age of father/sperm donor of the child? _____

3. What is your ethnicity/ancestry?

☐ Ashkenazi Jewish
☐ Asian
☐ Black/African American
☐ French Canadian
☐ Hispanic/Latinx
☐ Mediterranean
☐ Native American or Alaska Native
☐ Pacific Islander or Native Hawaiian
☐ Sephardic Jewish
☐ White/Caucasian
☐ Other _____

4. What is the ethnicity/ancestry of the father/sperm donor?

☐ Ashkenazi Jewish
☐ Asian
☐ Black/African American
☐ French Canadian
☐ Hispanic/Latinx
☐ Mediterranean
☐ Native American or Alaska Native
☐ Pacific Islander or Native Hawaiian
☐ Sephardic Jewish
☐ White/Caucasian
☐ Other _____

5. Do you have any religious reasons that you cannot receive blood products/transfusions? ☐ Yes ☐ No

6. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

- Neural Tube Defect, i.e., Spina Bifida (myelomeningocele or open spine), anencephaly ☐ Yes ☐ No
- Congenital Heart Defect ☐ Yes ☐ No
- Down Syndrome ☐ Yes ☐ No
- Tay-Sachs ☐ Yes ☐ No
- Canavan Disease ☐ Yes ☐ No
- Sickle Cell Disease ☐ Yes ☐ No
- Hemophilia ☐ Yes ☐ No
- Muscular Dystrophy ☐ Yes ☐ No
- Cystic Fibrosis ☐ Yes ☐ No

7. Do you or the baby's father have any close relatives with intellectual disability or autism? ☐ Yes ☐ No

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8. Do you or the baby's father have any close relatives with Fragile X? ☐ Yes ☐ No

9. Do you or the baby's father have diabetes, metabolic syndrome, celiac disease, PKU, or any other disorder that prevents you from metabolizing food without assistance? ☐ Yes ☐ No

10. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal disorder not listed above? ☐ Yes ☐ No

11. In this or any previous relationships, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? ☐ Yes ☐ No

12. Have you ever had chicken pox? ☐ Yes ☐ No

13. Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as chlamydia, herpes, gonorrhea, syphilis? ☐ Yes ☐ No

14. Have you or the baby's father ever had a positive test for HIV or been exposed to AIDS? ☐ Yes ☐ No

15. Have you ever had or tested positive for tuberculosis? ☐ Yes ☐ No

16. Are you and the baby's father related (besides marriage)? ☐ Yes ☐ No

17. Have you or the baby's father ever had hepatitis? ☐ Yes ☐ No

18. Do you work in the healthcare field? ☐ Yes ☐ No

19. Do you have cats? ☐ Yes ☐ No

20. Do you garden? ☐ Yes ☐ No

21. Have you traveled outside the country during pregnancy? ☐ Yes ☐ No

22. Have you had gestational diabetes in a previous pregnancy? ☐ Yes ☐ No

23. Have you taken any prescribed medications, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? If yes, please list medication and dose. ☐ Yes ☐ No

_____

_____

24. Have you had any previous pregnancies with a different practice? ☐ Yes ☐ No

If yes: _____

Date of delivery: _____

How many weeks when delivered: _____

Vaginal or Caesarean section: _____

Weight of baby: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

add columns _____ + _____ + _____

Total Score _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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PATIENT FINANCIAL POLICY

Thank you for choosing Chicago Women's Health Group as your healthcare provider. Our primary mission is to provide our patients with outstanding medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

You will be asked to fill out a new patient information form at your first visit. Please notify our office at your follow-up visit(s) if any of the information has changed.

All self-pay services must be paid prior to your visit. Please see the billing department when you arrive for your appointment.

As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. All copayments must be paid at the time of your visit. If you are not prepared to pay your copay, your appointment may be rescheduled. Payment of your balance after insurance is expected within 30 days unless payment arrangements have been made with our billing department. We accept cash, checks, Visa, MasterCard, Discover, and American Express. There is a $25 fee for checks returned due to insufficient funds. If you do not understand your statement or have questions regarding your balance, please feel free to contact our billing department at 312-943-0282 option 3 for clarification.

ADDITIONAL NOTES

Appointments must be canceled or rescheduled at least 24 hours prior to your appointment time or you will be subject to a $50 fee. We have reserved an appointment time for you and most likely will not be able to fill it at the last minute.

If you have any questions regarding billing, please contact our billing department at 312-943-0282 option 3 from 8:00 a.m. to 4:00 p.m. Additionally, you are always welcome to stop by our office when you are here for an appointment. We are happy to assist you!

Sign: _____ Date: _____

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CHICAGO WOMEN'S HEALTH GROUP OBSTETRICAL BILLING POLICY

Dear Patient,

We are pleased that you have chosen our practice for your obstetrical care. We would like to familiarize you with our obstetrical services as well as our billing policy. If you have any questions you would like to discuss, please call our billing department or stop by at any of your office visits.

Insurance and Your Obstetrical Care

We are happy to assist you in any way that we can in billing our charges for your obstetrical care and delivery to your insurance carrier. You must realize that you need to be aware of your own insurance benefits, as not all carrier coverage is the same. Our billing department can meet with you early in your pregnancy to explain the charges and global billing if you wish.

If we provide your complete care and delivery, we will be charging a "global obstetrical fee" after your delivery. Our current fees are $5,500 for a vaginal birth and $6,000 for a Caesarean birth. This fee includes your 13 routine prenatal visits to your doctor, our charges for the delivery of your baby, and your routine postpartum visit. Any other services that we provide, including your initial pregnancy visit, ultrasounds, lab tests, genetic tests, and non-stress tests, are charged separately. Additionally, visits that are not specifically pregnancy-related, such as visits for urinary tract infection, sore throat, etc., are also billed separately. If you change insurance carriers during your pregnancy, they require that we bill each charge separately to the proper carrier. The "global fee" will no longer apply. There is also a $500 charge for circumcision of a male infant if desired.

Obstetrical Deposit

All patients with verified commercial insurance are required to pay a deposit based on insurance benefits. The minimum deposit will be $500. The deposit is due in full or in four monthly installments. If you opt for the installment plan, your first payment will be due at your second prenatal visit, and the final payment will be due by the beginning of your seventh month. After you deliver, we will bill your insurance for your delivery and prenatal care. Your deposit will be used to cover any amount your insurance did not pay. If there is a still a balance on your account, you will be billed. If there is a credit from your deposit, it will be refunded to you.

If you are a self-pay patient, your entire global delivery fee must be paid upfront.
Our billing department will meet with you at your first prenatal visit to go over the billing plan.

Please feel free to contact our billing department at 312-943-0282 option 3 from 8:00 a.m. to 4:00 p.m. or stop by at the time of your visit. We will be happy to answer any questions.

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OBSTETRIC ULTRASOUND POLICY

During your pregnancy, you will most likely have several ultrasounds. You are encouraged to discuss these scans with your doctor, who will be happy to explain the reason each scan will be important for you.

You will have the first one at your first prenatal visit to establish dates and to make sure that all looks normal with the pregnancy.

Your second one will be the Nuchal Translucency scan. This scan looks at your baby's neck and helps to assess the risk for Down Syndrome and other genetic problems in the baby. This scan is optional.

The next scan is at approximately 20 weeks. This is an anatomy scan. Our sonographers will look over your baby from head to toe to look for anything that may not be developing normally. Also done at this time, is a scan to check the length of your cervix, which can indicate whether your cervix may not be competent to hold the baby to term.

Another ultrasound scan is usually done around 36 weeks to check the size of your baby and to make sure everything looks as it should.

The cost of ultrasound is $400-$500 per scan. These will be billed to your insurance carrier.

If you are having any health issues or problems with your pregnancy, additional scans may be needed.

Recently, we have found that insurance is limiting the number of ultrasounds that they will cover. While our ultrasounds are billed with the appropriate procedure and diagnosis codes, we are finding that insurance is occasionally denying coverage. Any ultrasound scans not covered by your insurance will be your responsibility.

Please sign below indicating that you have read and understand our ultrasound policy.

Thank you.

Chicago Women's Health Group

Name _____

Signature_____

Date_____

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HIPAA PRIVACY RULE

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearinghouses, and those healthcare providers that conduct certain healthcare transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The paragraph at the bottom of this page is an addendum to our notice of Privacy Practices (see Notice of Privacy Practices). Some exciting changes in the Electronic Health Record (EHR) system across the physician practices at Northwestern are taking place. The eventual plan is for all physician practices to be able to access all their patients' electronic records within the Northwestern physician system (e.g., your internist will be able to look into your lab results at your gynecologist's office and see that you had a Pap and it was normal).

Please read the paragraph below. If you wish your information to be accessible to your other doctors at Northwestern, please opt in to this program. Please feel free to ask should you have any questions.

This practice is using an Electronic Health Record (EHR) information system in coordination with Northwestern Memorial Hospital (NMH). The collection and use of all information through the EHR system is primarily for the purpose of treatment of patients by NMH, this medical practice, and other medical practices in a clinically integrated care setting. The information collected through the EHR system may include information regarding my diagnosis and treatment for mental health, developmental disabilities, HIV, AIDS, drug and alcohol abuse, genetic testing and counseling. The EHR system is not equipped to segregate such data from my other health information. All information collected through the EHR system may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and healthcare providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, which may include: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR system and any related database for any of the above activities.

Please check the appropriate box and print, sign, and date.

☐ I have read the privacy practices and consent to sharing my information with Northwestern providers

Sign: _____ Date: _____

☐ I have read the privacy practices and DO NOT consent to sharing my information with Northwestern providers

Sign: _____ Date: _____

CHICAGO women's HEALTH GROUP

CHICAGO WOMEN'S HEALTH GROUP AT NORTHWESTERN NOTICE OF PRIVACY PRACTICES

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

A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide detailed Notice in writing of our privacy practices. We know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in this Notice.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called "Protected Health Information" or "PHI." This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. Note that the reference "you" as used in this Notice refers to our patient even though this notice may be delivered to a parent or guardian of a patient that is a minor.

We are required by law to:

A. Maintain the privacy of PHI about you
B. Give you this Notice of our legal duties and privacy practices with respect to PHI
C. Comply with the terms of our Notice of Privacy Practices that is currently in effect

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official.

II. HOW WE MAY USE AND DISCLOSE PROCTED HEALTH INFORMATION ABOUT YOU:

A. Uses and Disclosures for Treatment, Payment, and Healthcare Operations.

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or healthcare operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Treatment: We may use and disclose PHI about you to provide, coordinate or manage your healthcare and related services. We may consult with other healthcare providers regarding your treatment and coordinate and manage your healthcare with others. For example, we may use and disclose PHI when you need a prescription, lab work, an x-ray, or other healthcare services. In addition, we may use and disclose PHI about you when referring you to another health provider. For example, if you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to any medications.

Payment: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are about to receive. For example, we may ask for payment approval from your health plan before we provide care or services. We may use and disclose PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose PHI to insurance companies providing you with additional coverage. We may disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us. We may also disclose PHI to another healthcare provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that healthcare provider, company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

Healthcare Operations: We may use and disclose PHI in performing business activities which are called healthcare operations. Healthcare operations include doing things that allow us to improve the quality of care we provide and to reduce healthcare costs. We may use and disclose PHI about you in the following healthcare operations: (i) reviewing and improving the quality, efficiency, and cost of care that we provide to our patients (for example, we may use PHI about you to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment we provide to others); (ii) reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you and other patients; (iii) providing training programs for students, trainees, healthcare providers, or non-healthcare professionals (for example, billing personnel) to help them practice or improve their skills; (iv) cooperating with various people who review our activities (for example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with the law and managing our business); (v) reviewing our activities and using or disclosing PHI in the event that we sell our practice to someone else or combine with another practice; and (vi) business management and general administrative activities of our practice, including

managing our activities related to complying with the HIPAA Privacy Rule and other legal requirements.If another healthcare provider, company, or health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain healthcare operations of that healthcare provider or company. For example, such healthcare operations may include:
reviewing and improving the quality, efficiency, and cost of care provided to you; reviewing and evaluating the skills, qualifications, and performance of healthcare providers; providing training programs for students, trainees, healthcare providers, or non-healthcare professionals; cooperating with the outside organizations that evaluate, certify, or license healthcare providers or staff in a particular field or specialty; and assisting with legal compliance activities of that healthcare provider or company. We may disclose PHI for the healthcare operations of an "organized healthcare arrangement" in which we participate. An example of an "organized healthcare arrangement" is the joint care provided by a hospital and the doctors who see patients at the hospital.
Communication from Our Office: We may contact you to remind you of appointments and to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

B. Other Uses and Disclosures We Can Make Unless You Object.

Individuals Involved in Your Care or Payment for Your Care: We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care of payment for your care. If you are present and able to object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests. For example, if you are brought into this office and are unable to communicate normally with your physician for some reason, we may find it is in your best interest to give your prescription and other medical supplies to the friend or relative who brought you in for treatment. We may also use and disclose PHI to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other things that contain PHI about you.

C. Other Uses and Disclosures We Can Make Without Your Written Authorization or Opportunity to Agree or Object.

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply.

Required by Law: We may use and disclose PHI as required by federal, state, or local law. Any disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities: (i) to prevent or control disease, injury, or disability; (ii) to report disease, injury, birth, or death; (iii) to report Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities; (iv) to locate and notify persons of recalls of products they may be using; (v) to notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or (vi) to report to your employer (with notice to you), under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to an oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the healthcare system, government healthcare programs, and compliance with certain laws.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery request, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: We may, if we deem it appropriate, disclose certain PHI to law enforcement officials for law enforcement purposes.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person or determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation or transplantation.
Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.
To Avert a Serious Threat to Health or Safety: We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.
Specialized Government Functions: Under certain circumstances, we may disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.
Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Medical Emergency: We may use and disclose PHI in the case of a medical emergency, in the event you have not yet received a copy of this Notice at the time of such emergency treatment.

D. Other Uses and Disclosures of PHI Require Your Authorization.
All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and healthcare operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. We are not required to agree to your request. If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency.

To request restrictions, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); (3) to whom you want those restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. This practice is using an Electronic Health Record (EHR) information system in coordination with Northwestern Memorial Hospital (NMH). The collection and use of all information through the EHR system is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. All information collected through the EHR system may also be shared with and used by NMH and certain other hospitals, academic institutions, and healthcare providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR system and any related database and incorporating it into a data warehouse maintained by NMH. The EHR system is not equipped to segregate such data as mental health, HIV, drug and alcohol abuse, and genetic testing information.

The patient acknowledges that this practice is using an Electronic Health Record (EHR) information system in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR system is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting.