Sam Speron, M.D., F.A.C.S.

950 N. Northwest Highway
Park Ridge, Illinois 60068 Suite 102
Office (847) 696-9900 Fax (847) 696-9913

Sam Speron, M.D., F.A.C.S.
Notice of Medical Privacy Practices

UNDERSTANDING YOUR HEALTH INFORMATION AND MEDICAL RECORDS

Each time you visit the office or call to speak with the doctor or other health care provider, information about you and your visit documented. This record contains your name, symptoms, health history and exam, test results, diagnoses, treatment given and plan for future care.

YOUR HEALTH INFORMATION RIGHTS

Your medical record is the physical property of the medical practice; however, the information within your medical record belongs to you. Federal and Illinois laws provide you with the following rights regarding your health information that is contained in the medical record that our office keeps about you.

*Right to obtain a copy of this Notice of Privacy Practices.
*Right to request certain restrictions on the uses and disclosures of your health information
*Right to inspect or receive a copy of your health record. We reserve the right to charge a reasonable fee for copying your records.
*Right to request an amendment to your health record if you believe it contains an error.
*Right to obtain a list of all the people and companies to which this practice has released your health information.
*Right to request that we communicate with you about your health care at a confidential phone number or address.
*Right to revoke your written consent to use or disclose your health information except when the use or disclosure has already happened.

Federal and Illinois laws also provide you with the right to be informed about and give your written authorization before any health information, including Highly Confidential Information, is disclosed, unless such disclosure is allowed or required by law. Examples of Highly Confidential Information are mental health treatment information, substance abuse prevention, treatment or referral; developmental disability services, HIV/AIDS testing and treatment, venereal disease treatment, sexual assault treatment, and testing and treatment for genetic disorders.

OUR OFFICE'S RESPONSIBILITIES ARE TO

*Maintain the privacy of your health information as required by law.
*Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
*Do what is required by this notice with regard to your health information.
*Notify you if we are unable to agree to your requested restriction on disclosure of your health information. (For example, if such information is subpoenaed by a court of law)
*Agree to reasonable requests to communicate your health information by an alternative method or at an alternative location.

USE AND DISCLOSURE OF YOUR HEALTH INSURANCE

Your health information will be used for your medical treatment, to obtain payment for your treatment, and to operate our healthcare business.

EXAMPLES OF HOW YOUR HEALTH CARE INFORMATION WILL BE USED AND DISLOSED

Your health information will be used for *treatment*:
For example: The physician, nurse or staff will collect and document information about you in your medical record.

This information may be disclosed to another physician of health care provider, (such as your primary care physician or a nursing facility), for your immediate care. This health care information will then be used for you treatment.

Your health information may be used for *payment*:

For example: A bill that includes some of your health information may be sent to you, to the person responsible for the bill or to a third party payer (such as your health insurance company or Medicare), or to a laboratory billing a third party payer. The type of information sent will include your name, other identifying information, diagnosis, procedures performed and supplies provided during your treatment. In some instances, we may need to send a copy of part or all of your medical record to your third party payer.

Your health information may be used for our *routine operations*:

For example: The physicians and nurses may use your health information to review the treatment you received and its outcomes. We compare cases to help us improve the quality and effectiveness of our healthcare services.

OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

Upon receipt of your written authorization to use or disclose your health information, we will use or disclose your health information to those persons or companies for which you give us your written authorization to do so. If you authorize us to use or disclose your information, you must complete our Release of Health Information Form. You may revoke your authorization in writing at any time except to the extent that the information has already been sent. If your health information includes Highly Confidential Information, we may only use and disclose this information for treatment or payment or as required by Federal or Illinois law or unless we are specifically authorized by you to do so.

We may, without your written authorization, release your health information for the purposes described below:

Business Associates: We provide some services through other persons or companies that need access to your health information to carry out these services. The law refers to these persons or companies as Business Associates. Examples of these Business Associates are our transcription service, collection agency and answering service. We require that they use appropriate safeguards to ensure the privacy of your health information.

Health Oversight Activities and Specialized Government Functions: We may disclose your health information to an agency that oversees health care systems and ensure compliance with the rules of government health programs such as Medicare and Medicaid, and under certain circumstances, the U.S. Military or U.S. Department of State.

Law Enforcement Officials, Medical Examiners and Coroners and Court of Administrative Orders: We may disclose your health information to the police, other law enforcement officials, medical examiners and coroners, and to the courts or administrative proceedings as allowed or required by law, or required by a court or other legal process.

Notification and Other Communications with Your Relatives, Close Friends or Caregivers: **YOU OR YOUR LEGAL REPRESENTATIVES MUST TELL OUR STAFF WHICH RELATIVES OR PERSONS MAY GIVE AND RECEIVE INFORMATION ABOUT YOU.** After learning who these persons are, we may disclose information, except for your Highly Confidential Information, to them as needed to care for you.

Funeral Directors and Organ, Eye and Tissue Organizations: We may disclose your health information to funeral directors as necessary to carry out their duties and as allowed by law, or to organ, eye and tissue organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Public Health Activities: We may report your identified and other health information to: public health authorities for the purpose of controlling disease, injury or disability; to the U.S. Food and Drug Administration for regulating certain products or activities; to governmental authorities about suspected or known child abuse and neglect, elder adult abuse and neglect, or domestic violence; to a person exposed to a contagious disease or has the risk of contracting or spreading a disease; to your employer and governmental agencies as required by federal and state laws regarding work-related illness or injury; to

prevent or lessen a serious or imminent threat to a person's or the public's health safety; or, to a public or private entity that is authorized to assist in disaster relief efforts.

_____ _____

Patient Signature Date Staff Initials Date

_____

Patient Name-Please PRINT

Sam Speron, M.D., F.A.C.S.

950 N. Northwest Highway
Park Ridge, Illinois 60068 Suite 102
Office (847) 696-9900 Fax (847) 696-9913

Written Disclosure

Please initial one of the following statements:

_____The doctors and staff at Sam Speron, M.D. have my permission to leave messages regarding my medical and/or financial condition on my answering machine.

_____The doctors and staff at Sam Speron, M.D. do **not** have my permission to leave messages regarding my medical and/or financial condition on my answering machine.

I, _____ (patient name), have given written and/or verbal authorization for the following people to discuss my medical and financial conditions with Sam Speron, M.D:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Patient Signature	Date
_____	_____
Printed Patient Name	Staff Initials and Date

Sam Speron, M.D., F.A.C.S.

950 N. Northwest Highway
Park Ridge, Illinois 60068 Suite 102
Office (847) 696-9900 Fax (847) 696-9913

Statement of Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask our billing department if you have any questions about our fees or Financial Policy.

*All patients must complete our **Patient Registration Form**

*YOUR CO-PAY OR FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

*We accept cash, check, VISA, Master Card, American Express and Discover

Usual and Customary Rates

We are committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. You are responsible for payment in full regardless of an insurance company's arbitrary determination of "Usual and Customary Rates."

Medicare

We accept Medicare assignment. As Medicare patient you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays. If you have supplemental insurance, we will bill them directly for you. Your supplemental insurance may not cover your Medicare deductible, or pay only a portion of your coinsurance due. You will receive a bill after the supplemental insurance has paid us.

HMO-PPO-POS

ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW YOUR COPAYMENT AMOUNT, YOU MAY USE OUR PHONE TO CONTACT YOUR INSURANCE COMPANY AND FIND OUT. We are members of many HMO's. Patients will not be billed for their care as long as we have the necessary referrals. Patients are responsible to bring referrals for their appointments. Please ask our billing department if you have questions.

Worker's Compensation

Patients being seen as a result of work-related injuries are still responsible for charges incurred by them. Please notify our office if y you have such a claim so that prior to the time of your visit we may verify coverage of your charges by your employer. If we cannot verify coverage, you will be responsible for payment of your charges. Also, if your employer does not remit payment for your charges within a reasonable period of time, we will bill you directly for your charges.

Legal or Accident Claims

If you are here as the result of an accident claiming, we require that you pay 100% of your charges at the time of service or provide us with your health insurance information so that we may bill them directly. We will also need the name, address, and phone number of the Accident Insurance Company and/or attorney. In case of a lawsuit, we will file a lien with them for the balance. **24 HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS AND/OR X-RAYS REPORTS, AND THERE IS A FEE FOR THIS SERVICE THAT WILL BE CHARGED.**

Filing Insurance Claims

In order to file a claim on behalf of the patient, we must have a copy of the insurance identification card with the complete claims filing address. Without this information, you will be billed directly. We file claims for Medicare, Medicaid, HMO, PPO, POS, Worker's Compensation, and surgical charges. Balances that remain unpaid may be sent to our collection agency.

Questions about your bill should be directed to our billing department at (847) 696-9900.

_____ _____

Signature of Patient or Responsible Party Please Print Patient's Name

_____

Date