FOX VALLEY CARE CENTER

New Patient Registration Form

Please Print

Today's Date	

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)	Name Normally Used (Nickname)

Address	Apt. No.	City	State	Zip

E-mail	Home Phone	Work Phone	Cell Phone

Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No.	State Issued

Employer Name	Employer City	Employer State	How Did You Hear About Us?

Do you consent to only vaccine information being shared with the Illinois ICARE registry? Yes____ No____

Permitted Automated Contact Method(s) (circle all that apply)

cell phone: text? voicemail? email:___________________________________ home phone : voicemail? work: voicemail?

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)	Home Phone

Occupation	Employer name	Work phone	Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.

Policy Holder's Name	D.O.B	Policy Holder's Social Security No.

Secondary Insurance Company Name	Group No.	ID/Certificate No.

Policy Holder's Name

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

PATIENT SIGNATURE

Patient/ Guarantor Signature: ____Date:______________________________

FOX VALLEY
CARE CENTER

Patient Medical History Form

NAME: ______________________________ AGE: ________ DATE: _______________

PHYSICIAN you were seeing previously: ______________________________

Other **SPECIALISTS** you currently see: ______________________________

____

SURGERIES

List **SURGERIES** you have had (include year, surgeon, and hospital): ______________________________

____

____

Date of last **Colonoscopy** ______________ Result?______________ Location?______________

Date of last **Bone Density/DEXA Scan**______________ Result?______________ Location?______________

Describe **HOSPITALIZATIONS/ILLNESSES** not included above (include year, hospital): ______________

____

____

MEDICATIONS

List all **CURRENT PRESCRIPTION MEDICINES** (include dosage, reason you take it, who prescribed it):

____

____

____

____

List all **OVER-THE-COUNTER MEDICINES**, vitamins, and food supplements that you take:

____

____

ALLERGIES TO MEDICATIONS (including reaction):______________________________

____

VACCINES

What year did you have your last:

tetanus shot ____________ flu shot ____________ pneumonia vaccine ____________ shingles vaccine ___________

PAST MEDICAL HISTORY: Have you had (circle):

ADD/ADHD	Óladder Problems	Eczema, Hives, Skin Conditions	Lung Disease
Allergies	Blood Diseases	Erectile Dysfunction	Muscle, Joint, Bone Problems
Anemia	Breast Cancer	GI Problems	Ovarian Cancer
Anethesia Complications	Cancer ______________	Headaches/Migraines	Psychiatric Illness
Anxiety Disorder	Chicken Pox	Heart Disease	Restless Leg Syndrome
Arthritis	Conginital Abnormalities	Hepatitis	Rheumatic Fever
Artificial Heart Valve	Constipation	High Blood Pressure	Seizures/Epilepsy
Asthma	Depression	Hypothyroidism	Sleep Apnea
Atrial Fibrillation	Developmental/Behavioral Disorders	Infertility	Stroke
Barrett's Esophagus	Diabetes	Insomnia	Thyroid Problems
Inherited Diseases	Ear/Hearing Problems	Kidney Problems	Variscosities
			Vision/Eye Problems

Other___________________

FOX VALLEY CARE CENTER

Patient Medical History Form

SOCIAL HISTORY

Ethnicity: (circle one) Hispanic Not Hispanic Race_________________ Preferred Language________________

Where do/did you work? ____________________________ What line of work are you in?________________________

What is the last grade in school that you finished?____________________________________

What is your marital status? (circle one) married single divorced separated widowed domestic partner

How often do you excercise? (circle one) none occasional moderate heavy

What is your sexual orientation? (circle one) heterosexual homosexual bisexual

What type of diet do you eat? (circle one) regular vegetarian gluten free Other?___________________________

What is your general stress level? (circle one) low medium high

Do/did you smoke? Yes____ No_____ How much?_______packs/day #of years______ Year you QUIT?______ When was the last time you tried to quit?_______ How many times have you tried to quit? ________ Have you ever quit successfully?______________

Do/did you drink alcohol? Yes____ No_____ How much?_______drinks/week #of years______ Do you ever feel you should Cut down on alcohol intake?Yes_____ No_____ Do people ever Annoy you by criticizing your drinking?Yes_____ No_____ Have you ever felt Guilty about your drinking? Yes_____ No_____ Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (an Eyeopener)?Yes_____ No_____

Do you consume caffine (coffee, tea, soda)? Yes_____No_______ How many caffeinated drinks per day?____________

Do you have a history of prescription drug abuse or addiction? Yes_____ No_____ If yes, which prescription?_____________________

Do you or have you used (circle): heroin marijuana cocaine methamphetamine chewing tobacco diet pills

Do you drive a car or motorcycle?Yes____No_____ Do you use seatbelts? Yes___No___ Do you wear a helmet? Yes____No___

Do you use sun block? Yes____No_____ Do you have a smoke alarm in your home? Yes_____ No_____

Do you keep guns and ammunition in your household? Yes_____ No_____ Are they kept in a safe place? Yes_____No_____

FAMILY HISTORY

Do you have any children? ______ If yes, list their names, ages, and any major medical problems:

____

Who in your *family* has/had the listed diseases below(circle if cause of death and write age of death):

heart disease _________________________________ genetic disorder _________________________________

diabetes _____________________________________ cancer (what type?)_______________________________

thyroid disease ________________________________ alcoholism ______________________________________

mental illness _________________________________ arthritis _______________________________________

glaucoma _____________________________________ asthma ____

allergies ______________________________________ stomach problems ______________________________

tuberculosis ___________________________________ high blood pressure _____________________________

List any other diseases that run in your family and specify your relationship to each family member listed.

____

____

____

FOX VALLEY CARE CENTER

Patient Medical History Form

WOMEN ONLY: GYNECOLOGY HISTORY

Age at first period _______________ Date of last normal period ___________ # of pregnancies ____________

# of live births __________ # of children living with you ________ # abortions/miscarriages ____________

Problems with pregnancies (circle) pre-term labor toxemia diabetes high blood pressure other:_________________

Current Birth control method __________________

Date of last Pap____________________ Result?___________________ Location?_____________________________

Date of last Mammogram____________ Result?___________________ Location?_____________________________

ADVANCED DIRECTIVE:

Do you have a living will? Yes_____ No_____ If not, are you interested in having one? Yes_____ No_____

REVIEW OF SYSTEMS: Please complete by circling the items below that you have RECENTLY experienced:

Constitutional:	significant weight change fever normal activity level fatigue loss of appitite night sweats
Eyes:	vision change eye pain eye redness eye itchiness eye swelling eye discharge
Ears/Nose:	difficulty hearing ear pain frequent nosebleeds sinus problems sneezing
Mouth/Throat:	sore throat bleeding gums snoring dry mouth mouth ulcers drooling facial swelling foul smelling breath
Cardiovascular:	chest pain arm pain on exertion shortness of breath while walking rapid heartbeat shortness of breath while lying down known heart murmur light-headed when standing
Chest/Breasts:	lumps tenderness discharge
Respiratory:	cough wheezing chest tightness pain when breathing noisy breathing rapid breathing
Gastrointestinal:	difficulty swallowing abdominal pain nausea vomiting diarrhea
Genitourinary:	urinary loss of control difficulty urinating blood in urine constipation blood in stool mucous in stool testicular pain vaginal discharge increased urinary frequency change in urination pattern
Musculoskeletal:	muscle aches muscle weakness joint pain joint swelling limited motion back pain soft tissue swelling previous injuries
Skin:	pain itchiness dryness flaking redness rash hives skin lesions/growths skin lumps mole changes insect bites nail changes
Neurological:	numbness weakness tingling burning shooting pain headache dizziness loss of conciousness seizures
Psychiatric:	depression anxiety insomnia stress loss of interest
Endocrine:	fatigue increased thirst hair loss increased hair growth cold/heat intolerance
Hematologic/Lymphatic:	swollen glands easy bruising

OTHER: ____

Authorization to Release Medical Information

Patient Name:_______________________________________ Date of Birth:_________________

Previous or New Provider:

Address:

Phone:
Fax:

RELEASE TO/FROM:
Fox Valley Care Center
151 Dundee Avenue
Suite C
East Dundee, IL 60118
Phone: 847-426-9396
Fax: 847-426-1086

1. **INFORMATION TO BE RELEASED:** (Check all applicable)
   ☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
   ☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other:______________

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: ____ Date: ______________________________

2. **RECORDS FROM THE TIME PERIOD:** ___/___ /___ through ___/___ /_____

3. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
   ☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
   ☐ Personal ☐ Workers' Compensation Claim ☐ Other: ____________

4. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

5. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

6. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature: ____ Date: ____________________________

Date of Birth: __________________ Home Phone: __________________ Work Phone: __________________

For office use only:

____
MR# Date Initials of Staff Member Sending

FOX VALLEY CARE CENTER

HIPAA Compliance Form

In order to comply with HIPPA, we need your permission to release your medical information.

Patient Name ____

Date of Birth ____

Email ____

Address ____

City, State, Zip ______________________________________

Please Circle Yes Or No

YES NO To leave medical information on my home answering system.

YES NO To leave messages regarding appointments on my home answering system.

Phone # we can reach you at:_________________________________
Cell home work (circle one)

Additional phone number(s)___________________________________
Cell home work (circle one)

You have my permission to speak with the following person(s) regarding any test results or health information.

Person's Name ____

Person's Phone # _______________________________________

Person's Relationship to You ______________________________

Person's Name ____

Person's Phone # _______________________________________

Person's Relationship to You ______________________________

Your Signature ______________________________________ Date ____________________

Please note: This document will be utilized until we are notified of any changes by you and will be updated each year for compliance.

FOX VALLEY
CARE CENTER

FVCC Financial Policy

Thank you for choosing us as your primary health care provider. In order to continue to provide you with the best services possible, it is necessary for you to read and sign this financial policy which will be kept on file in your chart.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, or has summed up an outstanding amount of $300 or greater, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. We will not be able to see you until it has been paid in full.

8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ________________________

Signature of patient or responsible party Date

FVCC Consent Form

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES.

I consent to have Fox Valley Care Center physicians and staff examine me, perform tests and procedures as they feel, in their judgment, are reasonable and necessary in the diagnosis and treatment of my case. No test or procedure will be performed without informed consent and prior approval by me. I acknowledge that no guarantees will be made to me as to the result of treatments and examinations done.

I assign to Fox Valley Care Center the medical and/or surgical benefits to which my dependents or I are entitled under my health insurance plan. I also agree if any insurance benefits due to my dependents or me is insufficient to cover the professional fees of our care, that I will be responsible for the payment of the difference, including any deductibles and co-payments. If insurance coverage is insufficient, denied or otherwise unavailable, I agree to pay for all the charges not covered by the insurance or third party payor(s). If I am insured under a managed care plan contracted with Fox Valley Care Center, I am responsible for payment of all co-pays, deductibles and non-covered services.

I consent to the use or disclosure of my protected health information by Fox Valley Care Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Fox Valley Care Center.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. Fox Valley Care Center is not required to agree to my requested restrictions, however, if Fox Valley Care Center agrees, then the restriction is binding on Fox Valley Care Center.

I understand I have the right to revoke this consent, in writing, at any time, except to the extent that Fox Valley Care Center has taken action in reliance of this consent.

I understand I have the right to review Fox Valley Care Center Notice of Privacy Practices prior to my signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Fox Valley Care Center. This Notice of Privacy Practices also describes my rights and Fox Valley Care Center duties with respect to my protected health information.

Fox Valley Care Center reserves the right to change anytime the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

With this consent, Fox Valley Care Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out Treatment, Payment and Operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Fox Valley Care Center may mail to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment and Operations, such as appointment reminder cards, patient statements and any health promotions for disease management, preventive care and wellness programs pertaining to my clinical care.

______________________ ______________________ ________

Print Patient Name | Signature of Patient (or Personal Representative) | Date

Joint Acknowledgement of Receipt of Fox Valley Care Center Notice of Privacy Practices and Office Policies

I acknowledge that I received Fox Valley Care Center Notice of Privacy Practices and Office Policies. I understand that the Notice describes the uses and disclosures of my protected health information by Fox Valley Care Center and informs me of my rights with respect to my protected health information. For more information, please contact Fox Valley Care Center Privacy Officer (847-426-9396).

____

Signature of Patient or Personal Representative | Date

____

Printed Name of Patient or Personal Representative | Date

FVCC Office Policies

We would like to thank you for choosing Fox Valley Care Center as your patient-centered medical home. We have written this document to keep you informed of our current office policies.

Office Hours: Our clinic is open: Monday and Tuesday 8:00am - 7:00pm
Wednesday 7:30am - 12:30pm Thursday 10:00am - 6:00pm Friday, 8:00am – 4:00pm

Appointments: **We see patients by appointment only.**

After Hours and Emergencies: For a serious emergency call 911 right away. If you are not sure and you call our office, please be sure to tell the person who answers the phone that it is an emergency. After hours you will reach our answering service. They will page the provider on call.

Urgent Need or Sudden Illness: We have a limited number of same day or "work-in" appointments available every day. These spots fill up quickly and are worked into the schedule, so there may be a longer wait before you are able to see the physician. You are expected to arrive at the time given by the appointment scheduler. This visit type is for urgent sickness only and we ask that you remain focused on that concern during this appointment. We can schedule an appointment for you at a later date to discuss any other concerns you may have.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. If notice is not received, there will be a no-show fee applied to your account for $35.00.

Arrival After Appointment Time: Any patient that arrives greater than 10 minutes past their scheduled appointment time may not be seen by the physician. ALL appointments are scheduled to ensure we can provide exceptional care to our patients. Though an appointment made may require a wait, we ask that you are here at the time we stated when scheduling the appointment.

Running on time: We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 30 minutes so we can double check to see if you have been properly checked in. Remember that we are running several different schedules. If someone who arrived after you is called before you, they might be on our lab schedule or seeing a different provider.

Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult and have written permission, for treatment, from a parent or guardian.

Lab Work: Some lab work is point-of care testing that we do in our office-like glucose tests, urinalysis, and hemoglobin A1C's. These tests are drawn by one of the medical assistants. Other lab work we send out to a reference lab. Usually this blood is drawn by the phlebotomist who is employed by the lab. In some situations, insurance company requirements dictate that a patient utilize a specific lab for their testing. If your insurance requires a specific lab, make sure you tell us every time.

Labs Ordered by Other Physicians: As a convenience to our patients, we will draw lab work which has been ordered by specialist physicians. If your specialist wants blood tests, but cannot draw them in his/her office, please make sure they complete an order, using appropriate diagnosis codes, for you to bring to our lab. If the lab tests are very specialized, we may refer you to the hospital for completion.

FOX VALLEY
CARE CENTER

FVCC Office Policies

Complete Physical Exams: We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover “wellness” and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

Prescriptions and Refills:

- The best time to get a prescription refill is at your appointment.
- If you need to call for refills, don’t wait until you have run out. Most refills require the doctor’s approval and can take 24-48 hours to be completed. If your doctor is out for the afternoon, it may be the next day (or Monday) before it can be authorized.
- Some medications have potential side effects that must be monitored. We require check-ups every 3 - 6 months for these medications. Be sure to keep those follow-up appointments.

Referrals: Referrals are handled by our Referral Dept. Sometimes this can be done on the same day as your appointment and sometimes it can take 5-7 days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained. When you receive the referral from our office you will have all the information needed for your specialist appointment.

Dismissal: If you are “dismissed” from the practice it means you can no longer schedule appointments, with any provider, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Noncompliance, which means you won’t follow physician instructions about important health issues
- Abusive to staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address, via certified mail and regular mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

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.

If you have any questions about this notice, please contact Dr. Carmen Fotso, 151 Dundee Ave Suite C, East Dundee, IL 60118.

WHO WILL FOLLOW THIS NOTICE

This notice describes our practice's privacy practices and that of:

Any physician or health care professional authorized to enter information into your medical chart.
All departments and units of the practice.
All employees, staff, and other office personnel.
All these individuals, sites, and locations follow the terms of this notice. In addition, these individuals, sites, and locations that may share medical information with each other or with third-party specialists for treatment, payment, or office operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

Ensure that medical information that identifies you is kept private;
Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care, provided you have consented to such disclosure. These entities include third-party physicians, hospitals, nursing homes, pharmacies, and clinical laboratories with whom the office consults or makes referrals.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff, and other office personnel for review and learning purposes.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care, provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the office; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to perform their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Fox Valley Care Center Medical record Dept. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.
To request an amendment, your request must be made in writing and submitted to [insert information]. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for our office;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to Fox Valley Care Center. Your request must state a time period, which may not be longer than 6 years and may not include dates before 01/01/2010. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to [insert information]. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Fox Valley Care Center. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

R**ight to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, send request to Fox Valley Care Center. 151 Dundee Avenue, Suite C, East Dundee, Il 60118.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Carmen Fotso, 151 Dundee Avenue, Suite C, East Dundee, IL 60118. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.