CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

REGISTRATION FORM

PLEASE FILL OUT ALL SECTIONS COMPLETELY

PATIENT INFORMATION

Name: _____ Prefer to be called: _____

Gender: ☐ Male ☐ Female Date of Birth: ___ /___ /_____

Social Security Number (For billing purposes):_____ Email Address: _____

Address: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____Work _____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work May we contact you via text? ☐ Yes ☐ No

Marital Status: ☐Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Ethnicity: ☐ Caucasian African American ☐ Asian ☐ Native American ☐ Other: _____

Preferred Language Spoken: _____

Emergency Contact Person: _____ Contact Number: _____

Employment Status: ☐ Fulltime ☐ Part Time ☐ Retired ☐ Homemaker ☐ Disabled

Occupation: _____

Employer: _____ Work Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____

Primary Insurance: _____

Subscriber Number: _____ Member ID: _____

Policy Holder's Name: _____ Relationship: _____

Preferred Pharmacy: _____

Address: _____ Phone: _____

You must provide a valid picture ID and your insurance card at the time of each visit, as well as any referrals required by your insurance company.

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____
Referring Physician: _____
Primary Care Physician: _____
Reason for Visit: _____

Please check any of the following that apply:

☐ Joint Pains	☐ Morning Stiffness	☐ Fevers	☐ Weight Loss	☐ Hair Loss
☐ Mouth Sores	☐ Pain in eyes	☐ Dry Mouth	☐ Chest Pains	☐ Shortness of Breath
☐ Palpitations	☐ Heartburn	☐ Abdominal Pain	☐ Nausea	☐ Diarrhea
☐ Blood in stool	☐ Pain w/ urination	☐ Weakness	☐ Numbness	☐ Tingling
☐ Rash	☐ Dry Eyes	☐ Vomiting	☐ Tingling	☐ Discolored fingers or toes in cold

Activity Level: Check any of the following you have DIFFICULTY with:

☐ Bathing ☐ Toileting ☐ Cooking ☐ Cleaning ☐ Exercise
☐ Other (please describe): _____

Please describe your current weekly exercise regimen:

_____

Personal Medical History

☐ Osteoarthritis	☐ Tendinitis	☐ Rheumatoid Arthritis	☐ Psoriasis
☐ Gout	☐ Osteoporosis	☐ Ankylosing Spondylitis	☐ Lupus
☐ Myositis	☐ Scleroderma	☐ Heart Disease	☐ Cancer (Specify): _____
☐ Asthma	☐ High cholesterol	☐ High blood pressure	☐ Diabetes (Specify): _____
☐ Fibromyalgia	☐ Kidney Disease	☐ Heartburn	☐ Thyroid (Specify): _____
☐ Pseudogout	☐ Psoriatic Arthritis	☐ COPD	

Other (Please list): _____

Surgical History: _____
Current Medications: _____
Medication Allergies: _____

Family History

☐ Rheumatoid Arthritis ☐ Psoriasis ☐ Lupus ☐ Vasculitis ☐ Gout
☐ Other:_____

Smoking Status: ☐ Non Smoker ☐ Former Smoker ☐ Current Smoker - packs per day: _____
Alcohol Use: ☐ No ☐ Yes - Amount per day: _____
Illegal Drug Use: ☐ No ☐ Yes -Please list: _____

Height (in inches): _____ Weight (in lbs): _____

Do Not Fill (for office use only)

BP: _____ HR: _____ Ht: _____ Wt: _____ Temp: _____

618 W Fulton St. Chicago, IL 60661 www.ChicagoArthritis.com Phone:773-347-7171 Email:admin@chicagoarthritis.com

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

HOUSE RULES

In order to obtain the best medical care possible, we expect the highest level of service and care from ourselves. We will always work closely with your primary care physician in order to provide the best and most appropriate care for you. We also expect patients to take an active role in their care and work within the guidelines that the clinic operates.

Appointments:

-We will always try to schedule your appointments promptly and at your convenience.
-If you cannot make an appointment, please give more than 24 hours' notice. We try to provide courteous and respectful care
to our patients and expect the same in return.
-If you do not show for a scheduled appointment or cancel less than **24 hours before a scheduled appointment, you** will be charged a no show or late cancellation fee. These fees are as follows:
New patient appointment- $450
Follow up appointment- $150
Ultrasound (per are)- $125
Injections: $300

Regenerative Medicine Procedure appointment (including but not limited to Platelet Rich Plasma and Stem cell treatments)-to be discussed during appointment

-Arrive 15 minutes before your scheduled appointment time in order to properly check in and prepare for your visit.
***Children under the age of 16 years old are NOT ALLOWED in the office. If you have a minor present, he/she MUST be accompanie*d by another responsible adult that is NOT the patient. We will not allow unaccompanied minors in the office.**

Refills/Prescriptions given at the time of your visit:

-Please make sure to ask for refills before leaving the office.
-We do not fill routine refill requests via the phone, fax, or email.
-You may be due for another appointment if you're due for refills, so please schedule one.

Laboratory Test Results, X-ray Results or any Medical Testing Results:

-With your written consent y(›U have access to your medical records from our office. However, we do not routinely give test results via the phone, fax or email.
-Follow up appointment is needed to discuss test results, interpretation, and plan with the physician.

Financial Policy

Acceptance of our financial policy is mandatory in order to be seen in our clinic. This includes having a credit or debit card on file with our office to cover any outstanding account balances. We comply with all appropriate state, federal, and medical regulations regarding protection of your information and privacy.

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

INSURANCE AND BILLING POLICIES

Below you will find a list of our office billing policies. These are NON- NEGOTIABLE policies and apply to every patient account.

1. Let us know if your insurance has changed in any way, even if only your policy number. We need this information in order to properly write for your medications, labs and radiology tests. We also require the patient's social security number for this as well. Your record will not be seen or shared with any outside facility. Our records are completely private.

2. If you are a member of an HMO, please make sure your primary care physician provides us with a REFERRAL before your appointment.

    1. ***You will be responsible for obtaining all required referrals for your office visit(s). If you are seen in our office without a referral you are responsible for the total cost of your visit.***

3. Co-payments are expected at the time of check-in. Cash and/or credit cards are the only method of payment accepted by our office for your co-payment. If you are unable to provide your co-payment at the time services are rendered you will be asked to reschedule your appointment.

4. You must have a current copy of your insurance card at every visit to be seen by the physician.

5. Our office makes every attempt to obtain payment from your insurance company in a timely manner,

6. Our office will contact you if there is ever any issue with our office receiving payment from your insurance company. If there are any problems receiving payment from your insurance company:

    1. You will have 30 days from the day of the denial to correct any issues with your insurance company that may be preventing our office from receiving payment.

    1. Our office will only bill your insurance company within a 90 day period after the date of the corresponding visit. After 90 days, if your insurance company has not paid your claim, payment is expected from you (the patient) in full. Our office will then provide you with the appropriate billing codes in order to bill your insurance company directly.

7. Billing Statements are sent out the first of every month (30 day cycle).

8. Within 90 days of your first billing statement you will have to complete one of the two options listed below.
    1. Pay your account balance in full.
    1. Set up a payment plan.
9. Failure to comply will result in your account being sent to a collection agency.

10. Once your account is in collections you will be required to make payment directly to the collection agency.

11. We require a form of payment on file, either credit or debit card, in case your account is over 90 days unpaid in which case your card will be charged for any outstanding balance.

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

FINANCIAL POLICY

General Rheumatology Services

Our clinic participates in many insurance health care plans. If you are unsure if this practice is in network with your specific health insurance carrier and your specific health insurance plan/policy, we encourage you to contact your respective health insurance company for clarification.

If you are covered by one of our accepted insurance plans, and can provide a valid insurance card or other evidence of coverage, we will bill your insurance for your rheumatology services. You are responsible for providing us with the most current copy of your insurance card at the time of service.

Illinois State law requires insurance carriers to pay claims within 30 days of receipt. In situations when your insurance carrier pays its portion and leaves you accountable for the remaining payment portion, you will be accountable to submit this payment within 30 days from receipt of our billing statement. If your insurance carrier delays or withholds payment for 90 days or longer, both the insurance and patient portions will become your responsibility. You will be billed for the total account balance, and if not paid within 90 days, your account will be sent to a collection agency. Payment plans are available if needed. If you intend to set up a payment plan with our office Payment plans are available for a six month time period. After the expiration of the six month time period your account is expected to be paid in full. You must contact our office within 30 days following the receipt of the patient responsibility statement. We strongly suggest you monitor your personal account with us, contact our Billing Department at 773-384-7171 EXT 111. As your balance ages beyond 30 days, we recommend calling your insurance carrier and requesting a "claim status report".

If you are not covered by one of our accepted plans, you must **pay in full at the time of service**. Please be aware that there could be additional charges at your office visit including ultrasound, injection, and medication charges if you have any additional procedures done during your visit. Many insurance plans do provide reimbursement for "out-of-network" care. Please contact your insurance company to determine how to submit a claim form and the rules governing visits to out-of-network physicians. A complete list of costs associated with office visits can be obtained at the front desk.

Regenerative Medicine Procedures

You must pay for your procedure in full, two weeks before services are rendered. Regenerative medical procedures are not covered by insurance plans. Regenerative medicine services include, but are not limited to Platelet Rich Plasma, Prolotherapy, Platelet Lysate, Bone marrow aspirate concentrate, and other Regenexx injection treatments. A financial quote for each individual procedure will be provided at your consultation. The quote will be valid for 90 days.

You are responsible for making sure your billing information and all appropriate referrals and documentation are in place prior to your visit with Siddharth Tambar MD and Chicago Arthritis.

CHICAGO ARTHRITIS
AND REGENERATIVE MEDICINE

Agreement to House Rules, Financial, Billing, and Insurance Policies

We will make a best effort to work with each patient and their insurance provider to reconcile any payment disputes. We strongly suggest you monitor your account carefully and we will ensure our best effort to make this as smooth a process as possible.

In order to ensure continuity of care with our practice, we require that you maintain credit card information on our secure database. We understand your concerns with providing us this confidential information but assure you that this information will be kept confidential. You will be given 90 days from the date of your first billing statement to either pay your balance in full or set up a payment plan with our office. We will not charge your credit card during that 90 days' time frame as you will have multiple opportunities to pay off any account balances.

CREDIT CARD INFORMATION

Name of Patient (Last, First, MI): _____

Name of Cardholder (Last, First, MI): _____

Card Type: ☐ M/C ☐ Visa ☐ AmEx ☐ Discover Expiration Date: ____/_____ CVV #: _____

Credit Card Number: _____

Billing Address: _____ Phone Number: _____

Authorized Signature: _____ Date: ___/___/_____

I hereby acknowledge receipt of the services, authorize Siddharth Tambar MD and Chicago Arthritis LLC to bill the credit card I have provided above to keep on file for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.
I have read, understood and agreed to this policy. (Parents or guardians complete if the patient is a minor.)

By signing below, I hereby acknowledge I have read all of the above in its entirety and agree to the house rules, financial policies, and insurance/billing policies of Siddharth Tambar MD and Chicago Arthritis.

_____ _____

Print Name **Date**

_____

Signature

618 W Fulton St. Chicago, IL 60661 www.ChicagoArthritis.com Phone:773-347-7171 Email:admin@chicagoarthritis.com

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

Chicago Arthritis Patient Code of Conduct Agreement

At Chicago Arthritis, we are dedicated to providing quality healthcare services to our patients. To ensure the well-being and comfort of all patients and staff, we have established this Patient Code of Conduct Agreement. We ask that you carefully read and adhere to these guidelines during your visits to our practice.

Patient Responsibilities:

1. **Civility Policy:** At Chicago Arthritis, we expect our staff to be civil and respectful of all patients, and we also expect our patients to treat their providers and ALL staff with civility, respect, courtesy and consideration. Failure to do so will result in discharge from the practice.

2. **Confidentiality:** Patients should respect the privacy and confidentiality of other patients and the information shared within the practice.

3. **Follow Medical Advice:** Patients should follow the medical advice and treatment plans prescribed by their healthcare provider.

4. **Payment Obligations:** Patients are responsible for any applicable fees, co-pays, or deductibles associated with their healthcare services and should make payment arrangements as needed.

5. **Medication Management:** Patients should inform their provider of all medications, supplements, and treatments they are currently using and follow prescribed medication regimens.

6. **Non-Discrimination:** Discrimination, harassment, or any form of offensive behavior or language towards staff or other patients based on race, gender, religion, nationality, disability, sexual orientation, or any other characteristic will not be tolerated.

7. **Safety:** Patients should adhere to safety guidelines and instructions provided within the practice, including proper use of medical equipment and adherence to infection control protocols.

8. **No Show/Cancellation Policy:** Patients who repeatedly miss appointments or cancel without adequate notice may be subject to our no-show/cancellation policy, which may include fees or limitations on future scheduling.

9. **Appointment Length:** To ensure adequate initial examination time, our New Patients are scheduled for 45-minute appointments with both the Doctor and the PA. Second visit appointments are scheduled for between 15-30 minutes depending on the patient and the Providers preference. All follow up appointments are scheduled for 15 minutes as a default unless the patient or Provider requests a longer appointment. If you feel a follow up longer than 15 minutes is necessary, please request it when scheduling.

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

10. **Late Arrival:** To allow for a more impactful visit, we expect all patients to be on time for their appointments. We ask that all patients check-in 30 minutes before their New Patient appointments and 15 minutes before their established patient visits. If you have not arrived within 15 minutes of your check-in time you may be rescheduled.

11. **Medical Records Policy:** Records are required for all New Patient appointments. Please notify the office if you are hand carrying records to your appointment. Your Provider may order specific testing, the results of which will be required for your follow up appointments.

12. **Insurance:** Our patients may require Prior Authorizations for injections, infusions, medications and some insurance plans require referrals. It is patients' responsibility to inform Chicago Arthritis if and when they have changes or additions to their insurance coverage so that we can update any existing Prior Authorizations and properly bill for services.

13. **Text Messages:** We use text messages to communicate with our patients for appointment reminders, appointment rescheduling, billing, surveys and other topics as needed. By signing you are agreeing to receive text messages from Chicago Arthritis. If you would like to OPT OUT please circle and let the front desk staff know that you do not want text messages. You may revoke this approval at any time.
    OPT OUT

Consequences of Violating the Code of Conduct:
Violations of this code of conduct may result in various actions, including, but not limited to, verbal counseling, written warnings, discharge from the practice, or reporting of serious misconduct to appropriate authorities.

By signing below, I acknowledge that I have read, understood, and agree to abide by the Chicago Arthritis Patient Code of Conduct Agreement. I understand that failing to adhere to these guidelines may have consequences as outlined above.

Patient's Full Name: _____

Patient's Signature: _____

Date: _____

CHICAGO ARTHRITIS
AND REGENERATIVE MEDICINE

ADVANCE BENEFICIARY NOTICE

Dear Patient,

In the event that your insurance company does not fully pay for your care or services rendered during any office visit, please be advised that you may be responsible for ALL or PARTIAL payment of the service provided.

Please note that our office will make every effort to get prior authorization and attempt to get your insurance company to cover all services rendered while you are here in the office. In addition to medications and tests there is always the possibility that your insurance company may not cover your entire office visit or other services we provide to you. Our staff will make every attempt to notify your insurance company and obtain your consent to any service outside a routine office visit. It is the patient's responsibility to know their own insurance plan and coverage at the time of each visit. The patient will be responsible for the prompt payment of all denied components.

ASSIGNMENT OF BENEFITS

I instruct and direct my Insurance Company, _____to pay by check made out to: Siddharth Tambar, MD and mailed to:

Siddharth Tambar, MD

618 West Fulton Street
Chicago, Illinois 60661

If my policy prohibits direct payment to the physician, I hereby instruct and direct you to make the check out to me and mail it as follows:

Siddharth Tambar,
MD 618 West
Fulton street
Chicago, Illinois
60661

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law: (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

For professional or medical benefits for services rendered. THIS IS A DIRECT ASSIGNMENT OR MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am ultimately responsible for any balance not covered by my insurance company.

I authorize the release of any information pertinent to the insurance company, adjustor or attorney involved in the payment of my claims.

_____ _____

Signature Parent/Guardian (if necessary) **Date**

Notice of Privacy Practices and Consent to Privacy Practices at Chicago Arthritis

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANO HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to ac«rss and control your protected health information. “Protected Health Information“ is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination in management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also ch‹›usr to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research , criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Nndcr the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization at any time, in writing.

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) — Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information — This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications - You have the right to request confidential communication from us by alternative means or an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information — If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach — We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or t‹› the Secretary of I Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint wiLh us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Privacy Officer:
1-773-348-7171
618 West Fulton Street
Chicago, Illinois, 60661

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Privacy Officer in person or by phone at our main phone number. Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Notices of Privacy Practices

I, ____have received a copy of the Notice of Privacy Practice at Siddharth Tambar MD and Chicago Arthritis, and I consent to the above privacy practices.

_____ _____

Signature Parent/Guardian (if necessary) **Date**

CHICAGO ARTHRITIS AND REGENERATIVE MEDICINE

Patient Authorization for Release of Medical Information

Patient name: _____ Date of Birth: _____

I hereby authorize the release of my protected health information to the following:

Siddharth Tambar, MD
618 West Fulton street
Chicago, Illinois 60661

Do Not Fill (for office use only)

Date: _____
Clinic/Physician Name: _____
Address: _____
Phone: _____
Fax: _____
Please send:
___All records (notes, labs, and reports) OR
___Specify item(s) only:_____

Notice to Patient

I fully understand that my medical records may contain psychiatric/developmental disability, alcohol/drug abuse, and or Acquired Immune Deficiency Syndrome / HIV test results and or Information. I understand that I have the right to inspect and or obtain a copy of disclosure. I understand that I may revoke consent at any time by giving notice to Siddharth Tambar MD or authorize office personnel. I absolve the individual or agency above from any legal liability which may arise from the disclosure of this information.

_____ _____
Printed name of patient **Signature of patient representative**

_____ _____
Signature of patient **Relationship to patient (if applicable)**