Woodridge Clinic

Woodridge Clinic
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Woodridge, IL 60517
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Woodridge Clinic - Lemont
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Lemont, IL 60439
Phone: (630) 754-8710
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Woodridge Clinic - Lombard
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Lombard, IL 60148
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NOTICE OF PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH INFORMATION AND MEDICAL RECORD:
Each time you visit a healthcare provider, they document information about you and your visit. This record is referred as your medical record and contains your name, symptoms, health history and exam, test results, diagnosis, treatment given and plan for future care or treatment. This medical record is used to plan your care and treatment and be a source of your health information.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION:
Woodridge Clinic, S.C. would use and disclose your health information contained within your medical record to give you treatment, obtain payment for your treatment and operate our healthcare business.

Upon receipt of your written authorization to use and/or disclose your health information, we will use and/or disclose your health information to those persons or companies for which you give us your written authorization or permission 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 we have already used or disclosed your health information as you previously authorized. If your health information contains highly confidential information, we may only use or disclose such information for treatment, payment and operations as described above. Otherwise, unless a disclosure is allowed or required by federal or Illinois law, you must give us your written authorization to disclose your highly confidential information. A person who can verify your identity must witness and co-sign an authorization to Release Health Information form about treatment for mental illness or developmental disability.

TREATMENT:
Our physicians or other members of our office will collect and document information about you in your medical record. We may disclose information to a physician or other healthcare provider who will be assuming your care, for immediate continuity of care. This information will be used to choose the treatment they believe is best for you. Pharmacies are an extension of healthcare providers who may also need information in order to effectively provide service for you.

PAYMENT:
We will send a bill that includes some of your health information to you, to the person responsible for the bill and your third party payer (such as your health insurance company or Medicare). In some instances, we may need to send a copy of part or all of your medical record to third party payees. The type of health information we will send includes your name, other identifying information, diagnosis, treatment and procedures performed.

BUSINESS ASSOCIATES:
We provide 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 our Business Associates. Examples of these Business Associates include billing and record copying companies that assist us in everyday operation, DME suppliers, collection agencies, creditors lawyers and telephone answering services. We may disclose your health information to our Business Associates so that they can do the job we have contracted with them to do. 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 healthcare systems and ensures compliance with the rules of government health programs such as Medicare or Medicaid; under certian circumstances to the U.S. Military or U.S. Department of State and for research purposes.

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 court order or other legal process.

NOTIFICATION AND OTHER COMMUNICATION WITH YOUR RELATIVES, CLOSE FRIENDS OR CAREGIVERS:
You or your legal representative must tell your physician or other healthcare team members which of your relatives or other persons may receive information about you. After learning who these persons are, we may, in our best judgement, use and disclose your health information, except for your highly confidential information, to notify these person(s) of what they need to know to care for you. In an emergency or other situation where you are not able to identify your chosen person(s) to receive communication about you, we may exercise our professional judgement to determine whether such a disclosure in your best interest, who is the appropriate person(s) and what health information is relevant to their involvement with your healthcare.

WORKERS COMPENSATION:
We may disclose your health information as allowed or required by Illinois law relating to Workers Compensation or to other similar programs.

YOUR HEALTH INFORMATION RIGHTS:
Your medical record is physical property of WOODRIDGE CLINIC, however the information within your medical record belongs to you. Federal and Illinois law provide you with the following rights regarding your health information that is contained in the medical record that WOODRIDGE CLINIC keeps about you.

- Right to obtain copy of this Notice of Privacy Practices.
- Right to request certain restrictions on the uses and disclosures of your health information.
- Right to inspect and receive a copy of your health record
- 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 the WOODRIDGE CLINIC has released your health information (accounting of disclosures)
- Right to request that we communicate with you about your health care at a confidential phone number or address
- Right to revoke our written consent/authorization to use or disclose your health information except when the use or disclosure has already happened.
- Out-of-pocket payments restrictions. In line with other changes mandated by the HITECH Act, patients have a right to restrict certain disclosures of Patient Health Information to a health plan, if the patient has paid out-of-pocket in full for the health care item or service.
- Breach notices. Patients have a right to be notified, if affected by an actual breach of their unsecured Patient health Information (PHI).
- Non-enumerated uses. Any uses and disclosures of PHI not described in the Privacy notice will be made solely upon written authorization from the individual The individual may revoke an authorization as provided in the regulations.

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 requited 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, veneral disease treatment, sexual assault treatment, and testing and treatment for genetic disorders.

RESPONSIBILITIES OF THE WOODRIDGE CLINIC:
- 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 or a Notice that is in effect at the time Woodridge Clinic office uses or discloses your health information.
- Notify you if we are unable to agree to your requested restriction on disclosure of your health information.
- Agree to reasonable requests to communicate your health information by an alternative method.

We reserve the right to change our privacy practices and to use a new Notice of Privacy Practices for all health information we maintain about you and other patients. If Woodridge Clinic changes its practices, a new Notice of Privacy Practices will be available upon your request by mail or in person at this site.

RIGHT TO FILE A COMPLAINT
If you believe your privacy rights have been violated, you may file a complaint with the privacy officer of Woodridge Clinic or the office of Civil Rights (OCR) or the U.S. Secretary of Health and Human Services (HHS). We will not retaliate against you if you file a complaint with us or with the Directors of OCR or HHS.

If you would like to report Privacy Problem or want further information, PLEASE CONTACT: Privacy Officer, Woodridge Clinic, S.C. at (630) 910-1177.

Woodridge Clinic

PATIENT FINANCIAL POLICY

Thank you for choosing Woodridge Clinic S.C. as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION: A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include a phone number at which we can reach the patient. A signature by the responsible party is required.

INSURANCE CLAIMS:
Primary Insurance: We will file claims with the patient's health plan upon the patient's submission of proof of insurance (i.e., insurance/government card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, we expect payment at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at the time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days of us filing the secondary claim we may transfer financial responsibility to the patient and the balance will be due upon receipt, provided the secondary insurance allows this.

Medicare Patients: We are a participating provider for Medicare Part B (Physician Services). We expect you to pay your Medicare deductible and/or any services provided but not covered by Medicare. We will bill Medicare and your supplemental insurance directly.

Medicaid Patients: We provide care for Illinois Medicaid patients only. Medicaid patients are required to present a valid Medicaid card upon registration for each appointment. Patients who are required to meet a "Spend Down" will be financially responsible at the time of service for services rendered until their "Spend Down" liability is met. Questions regarding your individual benefits should be addressed with your caseworker.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected at the time of service.** If necessary, we can set up a payment schedule. Payment arrangements will be made with a signed Payment Agreement and the approval of the Practice Manager and/or Billing department.

Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS: We require the consent of a responsible party before treating children under the age of 18. The parent or guardian of the child will be asked to sign a consent statement on a separate form.

WORKERS' COMPENSATION: You must verify that your provider is approved to provide care under your employer's workers compensation plan.

If applicable, Workers compensation will be filed if the patient notifies us when scheduling the appointment and supplies billing information at check-in. Details of the accident will be required and a separate workers' compensation form must be completed.

METHOD OF PAYMENT: Acceptable methods of payment are cash, check, VISA, MasterCard, Discover and American Express. Debit/credit card payments can also be accepted by phone, or online.
A fee of at least $25 but no less than the amount charged by the bank will be added to the patient's account per submission in cases of returned checks for non-sufficient funds (NSF).

PAST DUE ACCOUNTS: Outstanding balances after insurance payment will be invoiced to the responsible party on a statement. Payment is due upon receipt of the statement.

Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice.

In the event an account is turned over for collection the person financially responsible for the account will be responsible for all collection costs including interest, collection fees, and reasonable attorney fees and court costs.

A patient may remit in full for all outstanding charges owed on account including amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. After two (2) consecutive missed appointments, a fee of $25 will be charged for next appointment.

ACCOUNT CONSULTATION: Physicians do not discuss financial issues. Our billing staff and this office staff are trained to discuss your account and make payment arrangements. They will be happy to help you, but if you need further assistance please ask to speak with the Practice Manager or call the Billing Office at 630-910-1177 ext. 131, 141, 142, 143, 144.

MEDICAL RECORDS: If you need us to transfer your records to another physician, please contact us. We will provide you with the forms required to process this request. Cost of this service $10.00.

FINANCIAL AGREEMENT
I, the patient, or the patient's representative, acknowledge that I have read, understood and received a copy of the Woodridge Clinic S.C./ Woodridge Clinic –Lemont/Lilac Park Medical Center Financial Policy. I understand and agree, regardless of my insurance status, that I am responsible for the balance of my account.

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.

I have received the attached Notice of Privacy Practices for Woodridge Clinic, S.C.

Signature of Patient	Date
Patient Name (Please print)	Date of Birth of Patient
Signature of Parent/Legal Guardian/Legal Representative	Relationship to Patient
Witness	Date