CHICAGO ANTI-AGING INSTITUTE

Welcome and thank you for choosing **Chicago Anti-Aging Institute**. The following information is necessary for our office to serve you with complete accurate and seamless billing. If you need help, please ask the receptionist.

NEW PATIENT INFORMATION

First Name: _____ MI: _____ Last Name _____ Sex: ☐ M ☐ F

Birth Date: _____ Soc. Sec.# ____ - ____ - _____ Employer: _____

Street Address _____ City_____ State____ Zip_____

Primary Phone Number: (____) _____ - _____ Secondary Phone Number: (____) _____ -_____

Email: _____ **How did you hear about our office?** _____

I prefer my appointment reminders via: ☐ Text ☐ Email ☐ Both

Complete the following information and present your insurance cards with a valid form of photo identification to the receptionist.
**Please inform the front desk if you are here due to a Worker's Injury or Auto Accident

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other
Insured Name		
Insured Birthdate		
Insured Insurance ID#		
Insured Policy#		
Male / Female	☐ Male ☐ Female	☐ Male ☐ Female

WORKMANS' COMPENSATION OR AUTO INSURANCE	ATTORNEY'S INFORMATION
Date of Injury or Accident:	Name:
Insurance Company:	Address:
Insurance Address:	City, State, Zip:
City, State, Zip:	Contact Name:
Adjuster Name:	Phone Number:
Adjuster Phone Number:	File #/ Claim #:
File #/ Claim #:	

GROUPON #	VOUCHER #

Patient's Agreement: I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician(s) of Chicago Anti-Aging Institute to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process insurance claims by the provider or its agent(s). I fully understand and agree that my insurance policy is an agreement between myself and my insurance carrier and that any claims made by Chicago Anti-Aging Institute on my behalf are made only for my convenience and that I am responsible for all charges of Chicago Anti-Aging Institute, S.C., whether or not they are covered by my insurance. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. This shall remain in effect until revoked by me in writing. I designate Chicago Anti-Aging Institute and agent(s), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from Chicago Anti-Aging Institute. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of all services incurred. I also hereby give my consent to allow Chicago Anti-Aging Institute to contact me via text and/or email. I understand that charges may apply through my cell phone carrier if I opt to have contact through text. I hereby order all parties to accept a copy of this release and assignment in lieu of the original.

Patient or Guardian's Signature _____ Date _____

Office Use Only- CAAI #:

CHICAGO ANTI-AGING INSTITUTE

16622 W. 159th Street, Suite 500, Lockport, IL 60441

Confidential Comprehensive Health History

In order for us to provide you with the best possible health care, we *must* have a complete and accurate health history. Please take a few minutes to fill out the following pages. If you need help with any portion of this history please ask a member of our staff and they will be happy to assist you.

Thank you,

Name: _____
(Please Print)

Date: _____

CAAI #: _____
(Please leave this space blank)

Please list any other doctors you have seen in the past for the injury or symptoms you are having now. Also, please list any other doctors you are currently seeing for any condition.

1) Dr. _____ Specialty: _____

Phone #: _____ Date of first visit: _____ Date of last visit: _____

Reason for visit: _____

Were ❑ X-Rays ❑ MRI taken? ❑ No ❑ Yes, which body part? _____

The X-Rays revealed:_____

Was treatment received? ❑ No ❑ Yes, describe:_____

Are you currently being treated? ❑ No ❑ Yes Did treatments benefit you? ❑ No ❑ Yes

Were there any follow up instructions? _____

2) Dr. _____ Specialty: _____

Phone #: _____ Date of first visit: _____ Date of last visit: _____

Reason for visit: _____

Were ❑ X-Rays ❑ MRI taken? ❑ No ❑ Yes, which body part? _____

The X-Rays revealed:_____

Was treatment received? ❑ No ❑ Yes, describe:_____

Are you currently being treated? ❑ No ❑ Yes Did treatments benefit you? ❑ No ❑ Yes

Were there any follow up instructions? _____

3) Dr. _____ Specialty: _____

Phone #: _____ Date of first visit: _____ Date of last visit: _____

Reason for visit: _____

Were ❑ X-Rays ❑ MRI taken? ❑ No ❑ Yes, which body part? _____

The X-Rays revealed:_____

Was treatment received? ❑ No ❑ Yes, describe:_____

Are you currently being treated? ❑ No ❑ Yes Did treatments benefit you? ❑ No ❑ Yes

Were there any follow up instructions? _____

Please list any surgeries or hospitalizations you have had. _____

_____

Please list any medications that you are currently taking (if you have your medications already written on a separate sheet of paper, please give it to the front desk to photo copy for your records). _____

_____

Please list and describe any significant traumas you have had. (Auto accidents, falls etc.) _____

_____

Please list any known allergies that you have.

OCCUPATIONAL HISTORY: I work: ❑ Full Time ❑ Part Time ❑ Retired ❑ On temporary disability ❑ On permanent disability ❑ Homemaker ❑ Unable To Work ❑ Student

Please give a brief description of your current / most recent employment responsibilities. _____

SOCIAL HISTORY: **Your Current Age**_____ **Height**_____ **Weight**_____

Education level: ❑ Grade school ❑ High school ❑ Undergraduate ❑ Graduate ❑ Postgraduate

Caffeine: ❑ No ❑ Yes In what form? (i.e. coffee, soft drinks)_____ How much per day_____

Tobacco: ❑ Never ❑ Present - since _____ ❑ Past - from _____ to _____

In what form?_____ How much per day?_____pack(s)

Alcohol: ❑ Never ❑ Light ❑ Moderate ❑ Heavy ❑ Currently ❑ In the past, currently not drinking

Recreational Drugs: ❑ Never ❑ Present - since _____ ❑ Past - from _____ to _____

What kind?_____

EXERCISE & DIET HISTORY:

How many hours do you sleep each night? _____ What is the quality of that sleep? ❑Poor ❑Fair ❑Good ❑Excellent

Please list any vitamins, herbs or other dietary supplements you are currently taking. _____

FAMILY HISTORY:

Please list the names and age of the immediate members of your family. Spouse _____age ____

Child 1_____age_____, Child 2_____ age_____, Child 3_____ age ____

Please list any immediate family members who are deceased, how they died, and at what age. _____

WOMEN ONLY: Are you pregnant at this time? ❑ No ❑ Yes Have you ever been pregnant? ❑ No ❑ Yes

Have you ever had a cesarean section? ❑ No ❑ Yes

Please describe any complications you have had during or immediately following pregnancy. _____

Date of your last period_____My cycle is _____days. Flow: ❑Light ❑Medium ❑Heavy ❑Post Menopause

Date of last pelvic exam. _____Date of last Pap test _____ Results: ❑Positive ❑Negative

Have you ever been on birth control pills? ❑No ❑Past - From _____ to _____ ❑Present - Since : _____

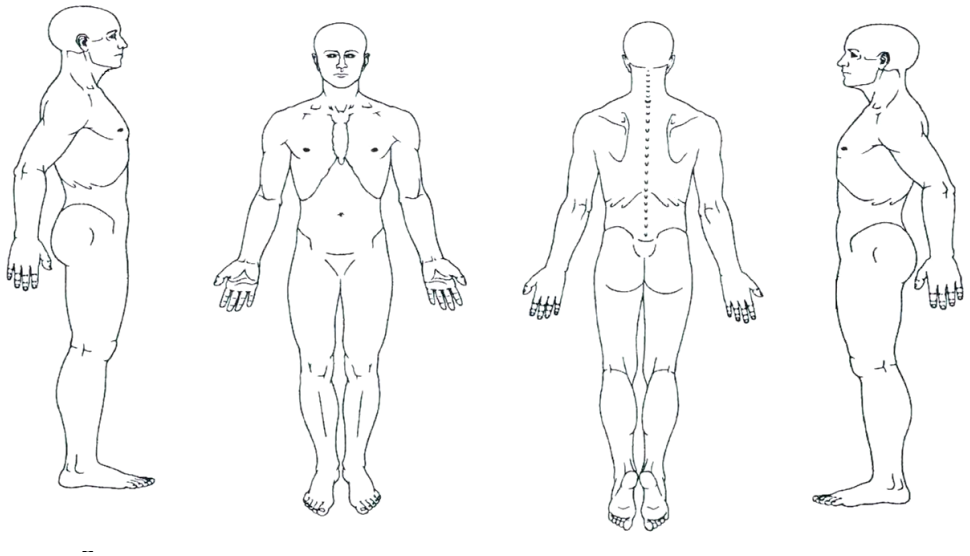
When was your last Mammogram? _____ ❑Never Had One

Masses or Lumps ever found in your breasts? ❑No ❑Yes If yes, what was the outcome? _____

Please Indicate On The Drawings Below Where Your Pain Is Generally Located

Briefly Describe Your Current Symptom(s) Here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Doctor's Notes: _____

_____

_____

_____

REVIEW OF SYSTEMS: Please check all the items that apply to you. Leave the item blank if you have never experienced any of the conditions.

	Currently	Past	MUSCULOSKELETAL	Currently	Past
Sore Muscles	❑	❑	Rheumatoid Arthritis	❑	❑
Poor Posture	❑	❑	Broken Bones	❑	❑
Scoliosis	❑	❑	Bone or Joint Disease	❑	❑
Sciatica	❑	❑	Harrington rods	❑	❑
Tendonitis	❑	❑	Spondylolisthesis	❑	❑
Stiff Joints	❑	❑	Joint Replacements	❑	❑
Swollen Joints	❑	❑	Disc Herniation in Neck	❑	❑
Bursitis	❑	❑	Disc Herniation in Upper Back	❑	❑
Arthritis	❑	❑	Disc Herniation in Lower Back	❑	❑

Doctor's Notes:

_____

_____

_____

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	RESPIRATORY	Currently	Past
Lung Problems	❑	❑	Pneumonia	❑	❑
Difficult Breathing	❑	❑	Whooping Cough	❑	❑
Persistent Cough	❑	❑	Tuberculosis	❑	❑
Coughing Phlegm	❑	❑	Pleurisy	❑	❑
Coughing Blood	❑	❑	Asthma	❑	❑
Wheezing	❑	❑	Bronchitis	❑	❑

Doctor's Notes:

_____

_____

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	GENITO-URINARY	Currently	Past
Kidney Problems	❑	❑	Bladder Trouble	❑	❑
Kidney Stone	❑	❑	Frequent Urination	❑	❑
Endometriosis	❑	❑	Excessive Urination	❑	❑
Gonorrhea	❑	❑	Scanty Urination	❑	❑
Syphilis	❑	❑	Painful Urination	❑	❑
HIV / AIDS	❑	❑	Prostate Problems	❑	❑
Chlamydia	❑	❑	Trouble Start / Stop Urination	❑	❑
Herpes	❑	❑			

Doctor's Notes:

_____

_____

_____

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	NERVOUS SYSTEM	Currently	Past
Loss of Feeling	❑	❑	Nervousness	❑	❑
Paralysis	❑	❑	Forgetfulness	❑	❑
Ringing in Ears	❑	❑	Fatigue	❑	❑
Dizziness	❑	❑	Depression	❑	❑
Fainting	❑	❑	Tension	❑	❑
Loss of Balance	❑	❑	Confusion	❑	❑
Irritability	❑	❑	Muscle Weakness	❑	❑
Convulsions	❑	❑	Nervous Breakdown	❑	❑
Epilepsy	❑	❑	Mental Disorder	❑	❑
Meningitis	❑	❑	Stroke / CVA	❑	❑
			Muscle Jerking / Tremors	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	CARDIOVASCULAR	Currently	Past
Heart Problems	❑	❑	Shortness of Breath	❑	❑
Chest Pain	❑	❑	Vericose Veins	❑	❑
Pain Over Heart	❑	❑	Hemorrhoids	❑	❑
Rapid Heart Beat	❑	❑	Arterial Problems	❑	❑
Pace Maker	❑	❑	Blood Pressure Problems	❑	❑
Anemia	❑	❑	Arm, Leg or Ankle Swelling	❑	❑
Poor Circulation	❑	❑	Chronic / Excessive Heartburn	❑	❑
			Trouble Breathing Laying Down	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	GASTROINTESTINAL	Currently	Past
Excessive Thirst	❑	❑	Liver Trouble	❑	❑
Diabetes	❑	❑	Gall Bladder Trouble	❑	❑
Excessive Hunger	❑	❑	Hernia	❑	❑
Poor Appetite	❑	❑	Ulcer	❑	❑
Nausea	❑	❑	Colon Trouble	❑	❑
Vomiting Food	❑	❑	Stomach Trouble	❑	❑
Vomiting Blood	❑	❑	Indigestion	❑	❑
Abdominal Pain	❑	❑	Jaundice	❑	❑
Diarrhea	❑	❑	Food Poisoning	❑	❑
Constipation	❑	❑	Drug Poisoning	❑	❑
Black Stool	❑	❑	Chemical Poisoning	❑	❑
Painful Bloody Stool	❑	❑	Rapid Weight Gain	❑	❑
Painless Bloody Stool	❑	❑	Unexplained Weight Loss	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient._____

	Currently	Past	OTHER DISEASES	Currently	Past
Measles	❑	❑	Diphtheria	❑	❑
German Measles	❑	❑	Scarlet Fever	❑	❑
Mumps	❑	❑	Polio	❑	❑
Chicken Pox	❑	❑	Cancer	❑	❑
Shingles	❑	❑	Eczema	❑	❑
Influenza	❑	❑	Eye Problems	❑	❑
Frequent Colds	❑	❑	Ear / Nose / Throat Problems	❑	❑
			New / Growing / Changing lumps, moles or lesions	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient. _____

The information contained on this history form, whether written or verbal, is truthful and accurate to the best of my knowledge.

Signature of patient: _____ Date_____

This history was read and reviewed with the patient by Dr. (print) _____

Signature of doctor: _____ Date_____

CHICAGO ANTI-AGING INSTITUTE

INFORMED CONSENT TO TREATMENT

I _____ do hereby give my consent to the performance of conservative treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/mobilizations involving movement of the joints and soft tissues. Physical therapy/modalities, acupuncture, stretching, exercises, spinal traction and diagnostic tests including but not limited to: EMG's, NCV's, EKG's, Spirometry, X-rays, Lasers, and blood draws may be also used.

Although spinal manipulation/mobilization is considered to be one of the safest, most effective forms of therapy for muscular-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- **Soreness:** I am aware that, like exercises, it is common to experience muscle soreness of following treatments
- **Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare
- **Fracture/Joint injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution
- **Stroke:** Although stroke happens with some frequency in our world, strokes from adjustments/mobilization are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chances of getting hit by lighting. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
- **Physiotherapy burns:** Some of the modalities used at Chicago Spine Institute generate heat and may rarely cause a burn or skin irritation. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctors.
- **Falls:** I understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries.

The only alternative to entirely avoiding these risks would be to forgo rehabilitation. I, therefore, acknowledge that falls and other similar injuries are an inherent risk of the rehabilitation process and accept that risk. Tests and other procedures have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I understand there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic and physiotherapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctors choosing.

ALTERNATE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me, including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

- **Medications:** Medications can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short term relief; undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

- **Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy including exercise programs and or stretching. Prolonged bed-rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
- **Non-Treatment:** I understand the potential risks of refusing, discontinuing and or neglecting care against the doctor's advice may include: increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.
- **Surgery:** Surgery may be necessary for joint instability or serious rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

I release Chicago Anti-Aging Institute from any responsibility for valuables, money and other personal possessions lost or stolen while on the premises. I consent to the administration upon me such as routine care, medications, and treatments, including diagnostic procedures, as may be considered necessary or advisable. I understand that I am free to obtain information concerning any such care by asking clinic personnel. I have read or someone has read to me the above explanation of Chicago Anti-Aging Institute, consent to treatment.

Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision, with careful thought, voluntarily, and freely. I understand that I can withdraw my consent at any time in writing.

To attest my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient: _____ Date: _____
Signature of Witness: _____ Date: _____

RELEASE OF DIRECT PAYMENT

In consideration of you undertaking to render care, I agree to the following:

Release of Information

You are authorized to release any information you deem appropriate concerning my medical condition and services provided to any insurance company, attorney, adjuster or any other person necessary for you to process any claim for reimbursement of charges incurred by me at Chicago Anti-Aging Institute.

Right to Receive Payment

I authorize and assign Chicago Anti-Aging Institute the right to receive direct payment from my insurance company, attorney, adjuster or any other party who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which Chicago Anti-Aging Institute is legally entitled.

Attorney Direction

I hereby direct my attorney not to interfere with or claim any lien upon any medical payment benefits to which I may be entitled from either my health insurance or any medical payment sources. And if any said medical payment check(s) include my attorney's name, I direct my attorney to sign his name to these check(s) for the benefit of Chicago Anti-Aging Institute.

Print Name: _____ Date: _____

Signature of Patient: _____

CHICAGO ANTI-AGING INSTITUTE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

16622 W. 159th Street, Suite 500, Lockport, IL 60441

Patient Last Name, First Name, MI	Date of Birth (mm-dd-yyyy)

To Institution:	
Address:	
City, State, Zip	
Phone Number:	
Fax (if Applicable):	

I, the undersigned hereby request and authorize the disclosure of my protected health information to the practitioner listed herein above. The purpose of this disclosure is for enclosure and accuracy of my medical history. I specifically request and authorize the release of all information regarding services rendered to me from _____to _____. Such Information is to include History and Physical, Results of Diagnostic Testing, Operative, therapy and procedure records and discharge summaries. In addition: I authorize the disclosure of the information contained in the highly confidential categories as indicated by my initials on the applicable line(s) below.

____ Mental Health or Developmental Disabilities

____HIV/AIDS Testing or Treatment

____Substance Abuse (Drug & Alcohol)

____Sexually Transmitted Diseases

I understand that I acknowledge that I voluntarily signed this authorization and that the information that is released will no longer be protected under the federal privacy laws.

I hereby authorize that A PHOTOCOPY OF THIS REQUEST SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Print Name: _____ Date: _____

Signature of Patient: _____

Print Name of Witness: _____ Date: _____

Signature of Witness: _____

Chicago Anti-Aging Institute, S.C.

PRIVACY NOTICE

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

Chicago Anti-Aging Institute is committed to maintaining the privacy of your protected health information (PHI). PHI includes individually identifiable health information and information that contains enough specific information that it can reasonably be used to identify the individual. This pertains to any information whether in electronic, written or oral form and also includes photographs of an individual as well as DNA samples. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care and to comply with certain legal requirements. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USES AND DISCLOSURES

Chicago Anti-Aging Institute (hereinafter called "the Practice") may use and/or disclose your PHI without your signed authorization in the following ways:

1. ***Treatment*** – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.

2. ***Payment*** – In order to get paid for services provided to you, the Practice will provide your PHI to appropriate third party payers. The Practice may also need to tell a third party payer about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense. Examples of third party payers would include Medicare and insurance companies.

3. ***Worker's Compensation*** – If you are involved in a Worker's Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Worker's Compensation system.

4. ***Health care Operations*** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

5. ***De-identified Information*** – Any information that does not contain items that can be used to identify you. For example, if the Practice publishes an article about low back pain, it can include information about the treatment and outcomes of their patients as long as information that would identify those patients (such as their name, social security number, photograph, etc.) was not included.

6. ***Business Associate*** – To a business associate of the Practice if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

7. ***Emergency Situations*** –
    a. For the purpose of obtaining or rendering emergency treatment to you, provided that the Practice attempts to obtain your consent as soon as possible.

    b. To a public or private entity authorized by law or by its character to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

8. ***Public Health Activities*** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

9. ***Abuse, Neglect or Domestic Violence*** – The Practice is required by law to make a disclosure to a government authority if it believes the disclosure is necessary to prevent serious harm.

10. ***When Release is Required by Law –***
    a. Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

b. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

c. Law enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, if your PHI is the subject of a grand jury subpoena or if the Practice believes that your death is a result of criminal conduct.

d. National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

11. ***Coroner, Medical Examiner or Funeral Director*** – The Practice may disclose your PHI to a coroner, medical examiner or funeral director for the purpose of identifying you or to help them in the performance of their duties.

12. ***Organ, Eye or Tissue Donation*** – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

13. ***Research*** – If the Practice is involved in research activities, your PHI may be used but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

14. ***Avert a threat to Health or Safety*** – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

15. ***Specialized Government Functions*** – This refers to disclosures of PHI that relate primarily to military and veteran activity.

16. ***Military and Veterans*** – If you are a member of the armed forces, the Practice may disclose your PHI as required by military command authorities.

17. ***Directory and Sign-In Log*** – At this time, the Practice does use a sign-in log at the reception window.

18. ***Informational Contact*** - The Practice may contact you regarding information about treatment alternatives or other health-related benefits and services by mail addressed to you at the address you have provided.

19. ***Email and the Internet*** – The Practice does not consider the Internet a secure method of communication and therefore, it will not discuss diagnosis, treatment or billing issues relating to a specific individual via the Internet.

    The Practice may respond to general information questions by email. The Practice may use email to inform you of any revisions to this Privacy Notice. It may also, periodically, contact you by email to inform you about events sponsored by the Practice or to send you its email newsletter. The Practice considers all email it sends to be both worthwhile and informative, however, at any time you can choose not to receive these emails by contacting the Practice. The Practice maintains privacy contracts with all third party contractors that have access to your email address. The Practice will not sell or distribute your email address to any non-contracted third parties.

20. ***Appointment Reminders & Missed Appointments*** – The Practice may contact you to remind you of a future scheduled appointment or a previously scheduled appointment that you have missed. This will initially be through the contact telephone numbers you have provided to us. Messages left for you will not include any specific information related to your diagnosis or therapy, but may include your name and the time and date of your appointment.
    The following appointment reminders may be used by the Practice:

    a. A postcard mailed to you at the address provided;

    b. Contacting you at home by telephone; if you are not available, the Practice may leave a message on your answering machine, voice mail or with the individual answering the phone.

21. ***Family, Friends and Personal Representatives*** – The Practice may disclose to your family member or other relative, your personal representative (legal guardian or person with a durable power of attorney), a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification of (including identifying or locating) a family member, a personal representative, or another person responsible for your care, your location or general condition or death. However, in both cases, the following conditions will apply:

a. If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

b. If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

22. ***Referral Boards and Thank You Cards*** – The Practice feels it is important to thank individuals when they refer others to our office for treatment. This is done in the following ways:

    a. A referral board located in our reception area lists individuals using only their first name and the first initial of their last name. Unique identifiers such as nicknames and titles will not be used without a signed written authorization.

    b. Thank you cards are sent to the referring individuals home address (or address on file). To protect the privacy of the person referred to our office, we will not include their name on the card.

    c. The Practice will not publish (or put into print) any patient names in our newsletters, general mailings or on our website without a signed authorization.

23. ***Spinal Screenings, Scoliosis Screenings, Lectures, Presentations & Seminars***– The Practice does not maintain any records of PHI collected from people at the above events beyond 30 days after the date of the event unless that person becomes a patient of the Practice. The Practice has no control over information given to the school nurse at a scoliosis screening.

Authorization - Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

1. Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Contact Person.

2. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice of what information you want to limit, whether you want to limit the Practice's use and/or disclosure, and to whom you want to limit. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

3. Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Contact Person. The Practice will accommodate all reasonable requests.

4. Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Contact Person at the address below. The Practice charges reasonable fees based on the actual cost of fulfilling the request. The Practice will determine the appropriate charge for providing the requested records and inform the requestor in advance of providing the records. If the requestor agrees to pay the fee in advance, the records will be provided. Otherwise, the records will not be provided, unless the Privacy Officer determines that the charge is burdensome to the requestor. According to Illinois law, the charges may not exceed the following: $20.86 handling fee plus 78 cents each for pages 1-25, 52 cents each for pages 26-50, and 26 cents each for pages 51 to end; plus actual costs for copying of items other than paper records. Double- sided pages will be counted as two pages. The Practice does not have the facilities to copy x-rays. The Practice will allow a patient or their personal representative to sign out x-rays. In certain situations that are defined by law, the Practice may deny your request and you will be sent a written denial notice by mail. If you receive a written denial notice you have the right to have it reviewed.

5. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Contact Person. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the existing information in your PHI is deemed accurate and complete. The Practice will respond to your request within 60 days of receiving it informing you that either an amendment was made or that it was denied. If you disagree with the Practice's denial, you will have the right to submit a written rebuttal letter stating your disagreement and have this letter added to your record.

6. Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Contact Person. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

7. Receive a paper copy of this Privacy Notice as well as updates to it from the Practice upon request to the Practice's Contact Person. You may also view and copy this notice from our website at www.caai.com which will be updated whenever revisions to this notice are made.

8. Complain to the Practice or to the Secretary of the U.S. Department of Health & Human Services if you believe your privacy rights have been violated. To file a complaint with the Practice, you must describe the violation that took place in writing to the Practice's Contact Person. A complaint form is available from the Practice to make this process easier. The Practice will send you a written response to your complaint. The law forbids the Practice from taking retaliatory action against you if you complain. Informing the Practice directly allows it the opportunity to correct the violation and the problems in its policies and procedures that allowed the violation to occur in the first place.

PRACTICE'S REQUIREMENTS

1. When there is a difference between federal and State law, the Practice is required to abide by whichever law maintains a higher level of confidentiality with respect to your medical information, as long as there is no direct conflict to the State law. In Illinois, a specific written authorization is required to disclose or release mental health treatment, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

2. The Practice:
    a. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy Practices with respect to your PHI.
    b. Is required to abide by the terms of this Privacy Notice or any update of this notice.
    c. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for any PHI that it maintains.
    d. Will distribute any revised Privacy Notice to you prior to implementation.
    e. Will not retaliate against you for filing a complaint.

PRIVACY CONTACT PERSON & PRIVACY OFFICER

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Contact Person and Privacy Officer, Loren C. Davis, D.C., by phone at 815-838-7746.

Attn: Contact Person
Chicago Anti-Aging Institute
16622 W. 159th St., Suite 500
Lockport, IL 60441

EFFECTIVE DATE

This Notice is in effect as of 08/24/2020 and replaces all prior versions.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. By signing below, I also acknowledge that any previous documentation under "Chicago Spine Institute, P.C." still remains true and valid.

Patient's Full Name Printed: Date:

Patient or Personal Representative Signature:

If you are signing as the patient's Personal Representative:

Print name of Personal Representative:

Describe your authority (e.g., Attorney-In-Fact or legal guardian):

**Please note, a parent may sign only if they are also the patient's legal guardian.

Witness Signature:

YOU HAVE A RIGHT TO HAVE A COPY OF THIS PRIVACY NOTICE