Olga Zarkh MD, Your Personal Doctor

*1401 W. Dundee Road, Suite 202, Buffalo Grove, IL 60089 * Phone: 847-818-7700 * Fax: 847-818-1718*

Patient Name_____ Social Security #_____

Sex □ Male □ Female Age_____ Birth Date_____ □ Single □ Married □ Widowed □ Separated □ Divorced

Street Address_____

City_____ State_____Zip Code_____

Mobile Phone # _____Provider ☐ Verizon ☐AT&T ☐TMobile ☐ Sprint ☐Other

Home Phone # _____Preferred Phone # ☐Mobile ☐ Home ☐Work

Fax# _____Skype Name_____

E-mail address_____

Emergency Contact Name_____ Relationship _____ Emergency Phone #_____

Employer_____Work Phone #_____

Pharmacy Name, Address_____Pharmacy Phone # _____

May we leave a message with health related matters on your mobile phone #? □ Yes □ No On your home phone # □ Yes □ No

May we send you a text (SMS) message regarding your health matters? □ Yes □ No To your e-mail □ Yes □ No Fax# □ Yes □ No

May we send your billing statement to your e-mail address? □ Yes □ No

Primary Insurance _____Policy #_____Group #_____

Policy Holder Name_____Relationship to patient_____ Birthday_____

Secondary Insurance (if any) _____ Policy #_____Group #_____

ASSIGNMENT AND RELEASE OF MEDICAL INFORMATION

I, the undersigned, have insurance coverage with _____and assign directly to Dr. Olga Zarkh all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions.

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Dr. Olga Zarkh for any services provided for me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its representatives any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In the Insurance assigned cases, the physician or supplier agrees to accept charge determination of the Insurance carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Insurance carrier.

Signature of insured_____Date_____

Patient's Signature_____Date_____

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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Olga Zarkh, MD, Your Personal Doctor to serve the health care needs for you and your family. We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

Address Change

- It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone, email or other contact information. We may send out lab results, pathology and appointment information in addition to billing statements.

Co-payments, Deductibles and Co-Insurance

- Co-payments are collected at the time of check-in. If co-pay is not paid at the time of service, it is subject to a late fee.
- Insurance deductibles, coinsurance, co-payments and fees for services that are not covered by your insurance policy, if known, are due at the time the service is rendered. If unknown, your estimated payment portion is due at the time the service is rendered. We accept cash, check and most major credit cards. Credit cards are subject to a 5% surcharge.

Billing

- If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis. Upon receipt of your billing statement, payment is expected within 30 days of the billing date shown on your statement. If the balance remains unpaid within 30 days, a late charge of 2% per month is applied to the account balance until the account is paid in full.
- Statements for the services rendered in the office of Olga Zarkh, MD, Your Personal Doctor are issued by the following companies: Olga Zarkh, MD; Lab Corporation of America; Quest Diagnostics; Dr. Stanislav Pavlovsky, MD (psychiatric treatment).
- For the most part, **the only services that are covered by insurance company are face-to-face visits performed in the office setting with the patient present.** Non-face-to-face providers (MD, NP-C, DC) work is NOT covered by insurance company and is patient`s financial responsibility.

Credit Card Authorization

- You hereby authorize Olga Zarkh, MD, Your Personal Doctor to obtain and store your credit card information for payment of patient statement balances. Your credit card will be charged for the remainder of the patient balance after we have received your insurance payment. You have a right to request that we call you before we process this charge. A receipt will be included with your statement and the statement will be marked as PAID IN FULL.

Failure to Pay

- Patients who ignore collection notices and fail to pay their balance risk negative credit ratings and possible dismissal from the practice.
- Past Due accounts may hinder your ability to have appointments scheduled.
- Should your account balance become uncollectible or if you file bankruptcy, we will continue to see you on an emergency basis only for 30 days, giving you time to find a new source of medical care.

Fees

- Returned checks are subject to a fee and your account will be placed on a “cash-only basis.” We will accept payments only by cash or credit card until the balance is cleared.
- Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge. See fee schedule for details. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, Olga Zarkh, MD, Your Personal Doctor requires a minimum of 24 hours’ notice.
- There is an administrative fee for completing forms such as DMV, physical forms, FMLA, leave of absence, disability etc. Most forms require 5 to 7 working days to research your information and complete the form.
- There may be additional charges applied to your account if we are asked to copy medical records per patient request or participate in a Deposition or Phone Consultation on your behalf.

Guarantor

- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Insurance

- **It is important for you to be an informed consumer, who understands the specifications of your insurance policy** (e.g., vaccine and doctor visit coverage, referral/authorization requirements for specialty care, radiographs, laboratory tests, urgent care facility care). Your health insurance policy is a contract between you and your Health Insurance Company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.

- **You must present a current insurance card at each visit**. As a courtesy to you, we will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered.
- If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement if your insurance pays the claim at a later date.
- If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full.
- Generally, insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed.
- If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.
- Olga Zarkh, MD, Your Personal Doctor contracts with many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the cost of care.
- If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

Minors and Dependents

- Parent and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed.
- The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.

Non-Emergency Appointments

- Outstanding balances or failure to pay co-payments upon check-in may result in physicals and other routine or screening appointments being rescheduled.

Prompt Payment

- Just as we make every effort to accommodate you when you are in need to medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office.

Referrals and Authorizations

- Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.
- Doctors and medical staff provide services, refer for diagnostic testing, consulting services and treatments in and outside the office based on medical necessity only, regardless of the coverage by the Insurance Company. Full Disclosure: Dr. Olga Zarkh, MD has **NO ownership interest** at any referral facilities, but "Personal doctor Olga Zarkh, MD Ltd" (DBA: Olga Zarkh, MD).

Refunds

- A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office.

Self-Pay Patients

- Self-pay patients should be prepared to pay at the time of each visit.

Worker's Compensation

- The patient must provide at time of service: a claim number, name of the carrier, the date of injury, employer at time of injury and name and number of the claim adjuster. Without this information, the patient will be held responsible for all charges, and payment will be collected at time of service.

I fully understand that I am responsible for any and all charges and/or fees associated with services rendered and/or efforts by "Personal doctor Olga Zarkh, MD Ltd" to collect on monies owed by me. If any account balance should remain unpaid and the account is referred to a collection agency, I agree to pay any applicable collection, attorney, court, credit bureaus and other fees associated to collect unpaid balance. I understand that such fees will be added to the account balance. My signature below indicates that I have read and understood the above statements and agreed upon them.

_____

Printed name of Patient

_____ _____

Signature of Patient or Legal Guardian Date

Olga Zarkh, M.D., Your Personal Doctor

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HIPAA Privacy Rule

(Health Insurance Portability and Accountability Act)

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access 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 or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. **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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment. We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment. Your protected health information will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. 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.

We may disclose your protected health information to medical school students that see patients in 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.

We will share your protected health information with a third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures of Protected Health Information based upon Your Written Authorization. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by laws as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object. We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure if the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare. With your authorization, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Emergencies. We may use or disclose your protected health information in an emergency treatment situation. If your physician or another physician in the practice is required by law to treat you, he or she may use or disclose your protected health information to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object. We may use or disclose you protected health information in the following situations without your authorization. These situations include:

Required By Law. We may use or disclose your protected health information to the extent, that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such use or disclosures.

Public Health. We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases. We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight. We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare systems, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, or to enable product recalls.

Legal Proceedings. We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in

response to a subpoena, discover request or other lawful process.

Law Enforcement. We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and local purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Criminal Activity. Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

Workers' Compensation. Your protected health information may be disclosed by us as to comply with workers' compensation laws and other similar legally-established programs.

Inmates. We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. sec.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

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 purpose of treatment, payment or healthcare operation. 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 restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting your written request to your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosure we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us upon request.

3. Complaints.

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

You may contact the office manager at 630.624.5022 for any additional information.

This notice was published and becomes effective on 1/01/08.

Patient's Name (print)_____

Patient's Signature_____Date_____