

Olga Zarkh MD, Your Personal Doctor

135 N. Arlington Heights Rd, Suite 160, Buffalo Grove, IL 60089

Phone:Text: **847-818-7700**

Email: info@yourpersonaldocor.com

Web: www.yourpersonaldocor.com

PATIENT CODE OF CONDUCT

1. Code of Conduct Statement

The reputation of Olga Zarkh Medical Office and its affiliates (“OZMO” or “our”) for integrity and independence is central to its mission of ensuring the public trust. This Client Code of Conduct (“the Code”) is fundamental to furthering OIZMO’s mission and applies to all OIZMO clients and their representatives. As an OIZMO client, you are expected to conduct yourself ethically and with integrity. You are also expected to act professionally and courteously in your dealings with OZMO employees and contractors.

2. Purpose

The purpose of the Code is to provide guidance to our clients so that they understand OIZMO’s expectations regarding a client’s behavior when dealing with OIZMO personnel and our expectations that each of our clients use only ethical business practices and are fully compliant with all applicable laws and regulations.

3. Guidance for Clients

In order to be in alignment with OIZMO’s #1 Core Value of Integrity, clients and their representatives must:

3.1. Act professionally and courteously at all times to OIZMO personnel;

3.2. Not attempt to intimidate or harass, sexually or otherwise, any OIZMO employee;

3.3. Not use profane, hostile or aggressive language with OIZMO employees;

3.4. Not engage in conduct which is fraudulent, corrupt, deceptive, misleading or harmful to the public;

3.5. Not submit insufficient or false information to OIZMO;

3.6. Not engage in any conduct which is in violation of applicable anti-bribery/anti-corruption laws and regulations;

4. Failure to Comply

4.1. Failure to comply with the Client Code of Conduct may result in OIZMO refusing to engage in any further transactions with the client and/or their representatives/third party

5. Acknowledgment

I understand that my compliance and my company's compliance with the Code is a condition of OIZMO providing services to me. I understand that OIZMO expects the highest degree of professional and personal ethics and integrity from its clients. I agree to treat all OIZMO employees with dignity and respect. I acknowledge that the Code does not identify every possible action that may violate the Code and that OIZMO reserves the right to refuse to provide any future services for conduct which it deems unethical or illegal.

I have carefully read and I understand the Code. I support these professional standards for OIZMO and for myself, and will act in accordance with them.

Print Name: _____ Signature: _____ Date: _____

<https://yourpersonaldoctor.com/index.php/patient-resources/forms-and-policies>

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Health Insurance Portability and Accountability Act (HIPPA)

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.

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 of 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 your 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.

Patient's Name (print) _____ Patient's Signature _____ Date: __/__/__

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OFFICE POLICY

OFFICE POLICY FOR INSURED PATIENT

Thank you for choosing Olga Zarkh, MD, Your Personal Doctor (“office”) 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 Policy. Please read this document thoroughly. It is a single policy acting as a contract between “office” and patient.

1. Demographics, Insurance, Contact and Credit Card information

- It is important that we have your correct address, insurance, phone number and credit information on file. We may remind you about an upcoming appointment based on the contact information we have on file. **Please provide a valid ID, insurance and credit card every time prior to any physical or virtual service.**
- Patient is responsible providing his/her current home/work/cell phone number, address, and email for communication needs. If an insurance changed, the patient has to send a copy of the insurance by email to: [**info@yourpersonaldoctor.com**](mailto:info@yourpersonaldoctor.com) at least 2 business days prior of the service day. Please contact us by email if we ‘work’ with your insurance regardless being ‘in-network’.

2. Eligibility, Benefits, Coverage and Other

- An insurance plan **may** cover the following services: office visit, tests, medical procedures, etc. Every insurance plan has its own regulations for benefits and coverage. Verification of benefit information is not a guarantee of payment by the insurance company. Coverage for a specific medical service is typically determined by the insurance company once a claim is received from the office. It is the patient’s responsibility to understand his/her insurance coverage before medical services are provided.
- There are many additional services such as phone consultations and requests which are typically not covered by insurance.
- Medical services and recommendations are based on the patient’s health needs only regardless of coverage, demographics, and/or financial status of a patient. Once a patient receives a medical recommendation it is his/her right to seek second opinion and determine if he/she wants to follow the recommended care.
- All services and products purchased at the office are NON-REFUNDABLE unless overpayment occurred.
- Any services not covered by insurance must be paid at the time of the service. If it not clear whether a service is covered or a situation requires urgent attention, the office reserves the right to bill the patient on or after the date of the service.
- A patient’s portion of the payment for service(s) is expected to pay at the time of the service(s).

3. Patient Financial Obligation (Co-payments, Deductibles and Co-Insurance, etc)

- The patient’s portion of the financial obligation is collected at the time of check-in. If it’s 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 are due at the time the service is provided. If benefit information is ambiguous or not accessible, your estimated payment portion is due at the time the service is rendered. We accept cash and most major credit/debit cards. Credit cards are subject to a 5% surcharge.
- A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office by email to: [**manager@yourpersonaldoctor.com**](mailto:manager@yourpersonaldoctor.com)

4. Billing.

- The office will send claim/s to insurance company to obtain payment/s for services rendered.
- If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed/e-mailed out on a regular 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. We have the rights to charge your credit card balance if an insurance company will not pay us in full based on fee schedule after 30 days claim sent. (Please see "Prompt Pay provisions in the Illinois Insurance Code")

5. Credit Card Authorization

6. 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 balance after 30 days since claim sent for the primary insurance and 60 days after for the secondary insurance. You have a right to request that we contact you by an email before we process this charge. A receipt will be included with your statement

7. 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.

8. Fees

- If the patient has Past Due account, he/she will be placed on a "cash-only basis."
- Failure to give a 24 hour cancellation notice **by email info@yourpersonaldocor.com** 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.
- There is an administrative fee for completing forms outside of insurance mandates.
- There are additional charges applied to your account if providers are asked by patient representatives (example: patient, patient relatives, pharmacy, hospitals etc) to do work outside of the insurance coverage (please see a fee schedule here: <https://yourpersonaldocor.com/index.php/patient-resources/forms-and-policies>). There would be no communication with the patient regarding the above requests.

9. 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.

10. Insurance

- **It is important for you to be an informed consumer, who understands the specifications of your insurance policy** (e.g., doctor visit coverage, referral/authorization requirements, tests, procedures). 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
- **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 might 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 30days. 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 30 days, the balance will be transferred to your account and you will be responsible for a 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 before services render to get 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 our providers are 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.

11. 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.

12. Prompt Payment

- Just as we make every effort to accommodate you when you are in need of 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. We reserve the right to ask you for the payment prior to any services and refund you if insurance company pays us later.

13. 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.

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

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(*)Patient Name _____

(*)Sex: Male _____ Female _____ Third Gender : _____ (*)DOB: __/__/__

(*)Address _____

(*)City _____ (*)State: _____ (*)Zip Code _____

(*)Mobile Phone # _____

Alternative Phones # _____

Mobile Phone Application You are using (for VIP or Telemedicine): WhatsUp, Signal, Telegram, Viber _____

(*)E-mail: _____@_____

Emergency Contact mandatory name _____ Relationship _____

Emergency Phone # _____

(*)Pharmacy Name: _____ Address _____

(*)Pharmacy Phone # _____

Primary Insurance _____ Policy # _____

Group # _____

Policy Holder Name _____ Relationship to patient _____

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: _____ (*)Date _____

(*)Mandatory fields