Global Health Partners
at Northwestern

Victoria Brander, MD
Board Certified, Physical Medicine & Rehabilitation

Kiran Chekka, MD
Board Certified Anesthesia and Interventional Pain Management

NEW PATIENT FORMS

Welcome to Global Health Partners at Northwestern. We are honored that you have chosen us for your musculoskeletal health care. **Enclosed are New Patient forms to be completed at your convenience at home. We prefer to review your completed forms *before* your appointment, so that we can properly prepare for your visit**. You can mail, email, fax or drop them off with us. Even though you sent the records ahead of time, please also bring your electronic or paper copy with you when you arrive for your appointment.

We ask that you complete these New Patient Forms *even if you have seen Dr. Brander or Dr. Chekka at their prior practices*. Thank you for your patience with what may seem as redundant paperwork, but it is important for us to insure our medical records are complete.

It is important for you to send us copies of your prior medical records, including MRI and X-ray FILMS (on CD or paper) and corresponding radiologist reports **prior to your appointment.** After we review your records, we may call you before your appointment in order to set up tests (such as an X-Ray) or get further information. We strive to make your office visit is as thorough and productive as possible. If you do not have copies of your records, please contact the rendering physician or facility and **have them faxed to our office at 1 (312) 926-7400** (prior to your appointment). For your convenience, attached is a request form for release of medical records that you can send to your prior physician or hospital. If your care was at Northwestern Memorial or the NorthShore system, we have access to those records electronically; you do not need to send in copies of those specific records.

It is important for you to **bring with you** ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING IN THEIR ORIGINAL BOTTLES.

What to bring with you to your appointment:

- ☐ Your current driving license and health insurance card
- ☐ All medications in their original bottles
- ☐ Your copy of your medical records, completed and signed New Patient forms, imaging and other relevant information
- ☐ A list of questions and goals for your visit

Please be prepared to spend at least an hour with us at your initial visit. Our physicians spend the time your care needs and deserves by performing a comprehensive medical history, physical examination and partner with you to develop an individualized treatment plan to achieve your goals.

Please visit our website at http://www.globalhealthpartnersnu.com/to learn more about our practice and explore the patient education information and videos to learn more about your health, possible treatments, and further understand our philosophy of care.

Again, we welcome you and look forward to our work together.

Victoria Brander MD and Kiran Chekka MD
Global Health Partners at Northwestern

737 North Michigan Avenue, Suite 960
Chicago, IL 60611

Tel (312) 416-4363
Fax (312) 926-7400

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DEMOGRAPHIC INFORMATION

LAST NAME:_____ **First Name:**_____ **MI**_____ Title: Mr / Mrs / Ms / Dr / NA / Or:_____

Date of Birth: _____/_____/_____ Date of Appointment: _____/_____/_____

Mailing Address:_____ City_____ State_____ ZIP_____

Preferred Phone (mobile / home) Day:_____ Evening:_____ Other:_____

Email Address: _____

May we leave a message with clinical information on your preferred phone? Yes / No

May we send you clinical information via email? Yes / No

EMERGENCY CONTACT:

Name: _____ Relationship:_____ Telephone: _____

If there is an urgent situation, may we discuss your care with your emergency contact listed above? Yes / No

PHARMACY:

Pharmacy Name_____ Address: _____

Pharmacy Telephone:_____ Fax: _____

PRIMARY CARE PHYSICIAN:

Name: _____Address: _____Phone/ Fax: _____

Other Clinicians you wish to receive copies of your clinical notes? _____

Who referred you to our practice? Name: _____Address: _____

INSURANCE

- ☐ Primary *Is this Insurance provided by a trade union? Yes / No*

  Insured's Name_____ DOB: _____SS#_____
  Insurance Co:_____Policy#_____Group#_____
  Address:_____Phone: _____Relationship to patient: _____

- ☐ Secondary

  Insured's Name_____ DOB: _____SS#_____
  Insurance Co:_____Policy#_____Group#_____
  Address:_____ Phone: _____Relationship to patient: _____

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Demographic information, continued

COVERED BY WORKERS COMPENSATION? ☐ NO or ☐ YES: Date of Injury:_____

Injury Description: _____

Last Treating Physician:_____ Address: _____Phone:_____

Employer at Time of Injury: _____ Contact Name_____

Address_____ Phone/ Fax_____

Worker's Comp Insurance Carrier: _____

Phone:_____ Address:_____

Adjustor/ Case Manager: _____Phone:_____ Fax: _____

Policy/Claim#_____ Group/TWCC#_____

The physicians of Global Health Partners at Northwestern provide expert and compassionate musculoskeletal care, unrushed, and highly personalized to meet each patient's needs. In today's era of healthcare (that of 10 minute office visits, call centers, and insurance mandated care restrictions), providing unrushed and personalized care is a nearly impossible. Thus, our practice has decided upon a different model. In order to insure sufficient time with patients to deliver the best of care, remove insurance company interference in health care decisions, and to maintain transparent and fair prices, our physicians do not contract with any third party insurer or healthcare system.

Therefore, it is important you understand and agree to the following:

- I understand that Global Health Partners at Northwestern, Dr. Brander and Dr. Chekka do not participate as in-network providers for any insurance, including Medicare and Medicaid, and they **do not bill my insurance for the work they perform.**
- I understand and agree that **I am required to pay the fees for the care I receive at the time of my visit** (except in cases of Workman's Compensation and in rare other circumstances, arranged in advance).
- I understand that **I may submit my payment receipt to my insurance for reimbursement at out-of-network rates, and whether and what I receive depends upon my specific insurance policy**.
- **I understand that I may continue to use my insurance for tests and treatments not obtained at Global Health Partners**, as per my specific insurance policy, and Global Health Partners will help obtain preauthorization or other needed approvals for those tests, treatments and medications.
- I agree that Global Health Partners at Northwestern may release any necessary medical information to insurance carriers concerning my illness/accident/injury.
- In cases of Workman's Compensation or third party reimbursement, I assign to Global Health Partners at Northwestern, Dr. Brander, or Dr. Chekka all payments for medical services rendered.

I read, understand and agree to the above conditions.

_____ _____
Patient Signature Date

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RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____Date of Birth: _____

Patient Address:_____Patient Phone:_____

By signing this form, I authorize: _____(healthcare provider) to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

I am requesting the following medical information be subject to this Release Form:

1. Last three office visits
2. Radiological reports
3. Lab reports
4. Last 3 procedure notes

Release the above listed protected health information to the following person(s) / entity:

Name: Victoria Brander MD and Kiran Chekka MD
Global Health Partners at Northwestern

Address: 737 North Michigan Avenue, Suite 960
Chicago, Illinois 60611
1 (312) 926-1600

Fax: 1 (312) 926-7400

The reasons or purposes for this release of information are as follows:

1. For evaluation and treatment of patient
2. For continuity of care
3. Other:

Patient Signature (or parent, guardian or legal representative)

X _____ Date: _____

Print Name: _____ DOB: _____

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NEW PATIENT MEDICAL HISTORY

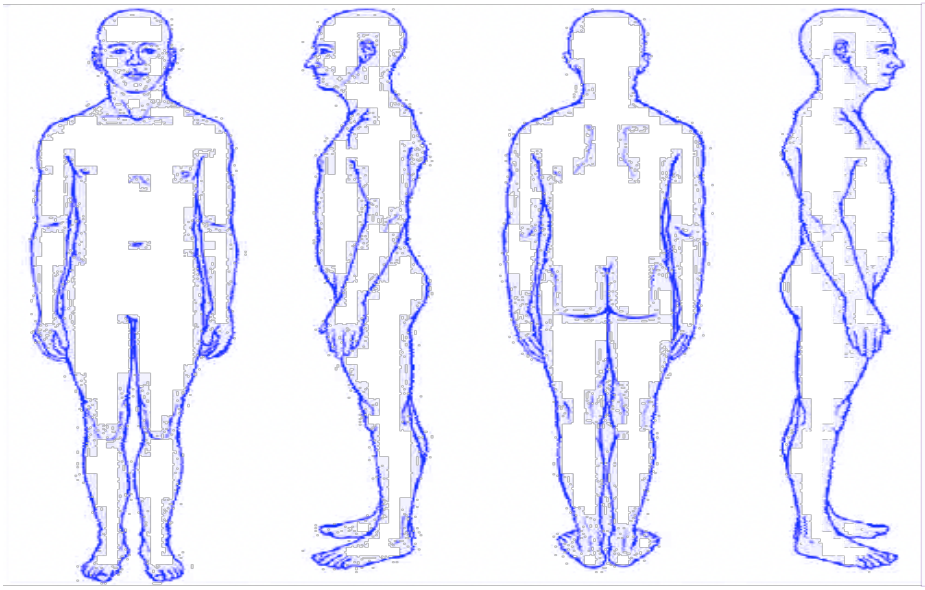
NAME:_____ AGE: _____ DATE OF VISIT:_____

REASON FOR YOUR VISIT? _____

List the areas of pain and disability, in order of importance (most severe first) and mark the location of each pain area on the figure below.

**To score your pain: use number range 0 = no pain to 10 = worst pain ever*

Pain location	When & how did pain start?	Pain score* ACTIVITY	Pain score* REST	Pain is made better by:	Pain is made worse by:	Prior tests and the results:	Prior treatments/doctors, including medications, and results:
1.							
2.							
3.							
4.							



Do you regularly awaken at night from pain?
NO / YES: # days/ week: _____

Which physical tasks are becoming hardest for you?

Are your symptoms *worsening* over time? If so, describe:

What or whom has helped you the most for your symptoms in the past?

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Patient Name: _____

CURRENT & PRIOR MEDICAL CONDITIONS	Date of Onset	Resolved? Date

CURRENT & PRIOR MEDICATIONS AND SUPPLEMENTS (name, dose & frequency)	Start/ Stop Date	Reason stopped

PAST SURGERIES & PROCEDURES	Date	Surgeon/ Hospital	List Complications

ALLERGIES	REACTION/DATE

Have you had any problems with anesthesia?
If yes, describe here:

OTHER SUBSTABNCE USE

Do you smoke or use tobacco? NO / YES, # Packs daily: ___ for ___years. Do you VAPE? NO / YES, describe: _____
If you are a former smoker, when did you quit? _____ Do you use marijuana? NO / YES, describe: _____

Do you drink alcohol? NO / YES., # drinks per week; _____. Do you use any other drugs? NO / YES, describe: _____
Do you have a history of substance abuse? NO / YES, describe: _____

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Patient Name: _____

SOCIAL HISTORY & LIFESTYLE

EMPLOYMENT

☐ I am currently working.
Employer: _____ Profession: _____
Please describe the physical requirements of your job:

☐ I am not working because of pain or disability
☐ I am working at reduced level because of pain/ disability
☐ I chose not to work at present

EXERCISE/ ACTIVITY

Recreational Exercise:
TYPE(s): _____Minutes/ week: _____

Physical Functioning:
How many minutes can you walk without rest? _____

Rate your pain level while walking on a level surface over the last week (0 = none 10= most pain ever experienced): _____

How many minutes can you stand without sitting? _____

Rate your difficulty level in doing the following
None (0), Mild (1), Moderate (2), Severe (3), Unable, or need help of another person (4). [indicate if you use cane or device]

Arise from sitting	_____
Standing	_____
Getting in & out of car	_____
Putting on shoes & socks	_____
Dressing myself	_____
Getting on and off toilet	_____
Bathing self	_____
Getting in/out of tub/shower	_____
Preparing meals	_____
Simple housekeeping	_____
Heavy housekeeping	_____
Lifting or carrying heavy items	_____
Gardening/yard work	_____
Performing your job	_____
Driving	_____
Caring for children/ others	_____
Travelling	_____

HOUSEHOLD

☐ I live alone
☐ I live with my (*circle one*): spouse/ partner / friend or:

Name: _____

Cell phone: _____
Do you have children? If YES, please list names (& phone numbers if you wish)

☐ I live in an apartment with no stairs
☐ I live in a house or apartment with stairs
stairs to enter _____ Handrail? YES. / NO
stairs to bedroom or bath _____ Handrail? YES ? NO

MY STRESS and ANXIETY LEVEL:

☐ I experience typical life stress or anxiety
☐ I am under heightened anxiety / life stress, but am coping well
☐ I am under heightened anxiety / life stress, and having difficulty coping

MOOD Please answer each question by circling the answer as follows:
1 = not at all 3 = more than half the days
2 = several days 4 = nearly every day

Over the last two weeks, how often have you been bothered by:

Little interest/ pleasure in doing things? 1 2 3. 4

Feeling down, depressed or hopeless? 1 2 3 4

Trouble falling or staying asleep or sleeping too much? 1 2 3 4

Feeling tired or having little energy? 1 2 3 4

Poor appetite or overeating? 1 2 3 4

Feeling bad about yourself – that you are a failure or disappointment? 1 2 3 4

Trouble concentrating? 1 2 3 4

Moving or speaking slowly, or the opposite (being fidgety or restless) so that people have noticed? 1 2 3 4

Thoughts that you would be better off dead, or hurting yourself in some way? 1 2 3 4

Total = _____ / 27. Depression level <5 none, 5-9 mild, 10-14 moderate, 15-19 moderate -severe, 20-27 severe

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Patient Name: _____

REVIEW OF SYSTEMS

General
- ☐ Weight loss / Weight gain
- ☐ Chronic Fatigue
- ☐ Recent feeling of poor health
- ☐ History of chronic pain
- ☐ OTHER:

Vision
- ☐ Loss or change in vision
- ☐ Double vision
- ☐ Scleritis/ episcleritis (red eyes)
- ☐ OTHER:

Head & Neck
- ☐ Headaches
- ☐ Eye pain
- ☐ Ear pain
- ☐ Forehead or scalp pain
- ☐ Ringing in ears
- ☐ Hearing loss/ change
- ☐ Voice change hoarseness
- ☐ Gum or teeth problems
- ☐ Difficulty swallowing
- ☐ Sense of mass in throat
- ☐ OTHER:

Pulmonary
- ☐ Shortness of breath with activity
- ☐ Shortness of breath at rest
- ☐ Chest pain
- ☐ Cough (chronic / acute))
- ☐ Coughing up blood
- ☐ Wheezing / Asthma
- ☐ Restrictive lung disease
- ☐ Snoring/ stop breathing at night
- ☐ OTHER:

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain/pressure with activity/ rest
- ☐ Shortness of breath awakens from sleep
- ☐ Loss of consciousness
- ☐ Light headed with posture changes
- ☐ Sense of rapid or irregular heart beat
- ☐ Calf/leg pain/cramps with walking / night?
- ☐ Leg ulcers or poor wound healing
- ☐ OTHER

Gastrointestinal
- ☐ Chronic GI issues?
- ☐ Heartburn / abdominal pain
- ☐ Nausea, vomiting
- ☐ Abdominal swelling- chronic
- ☐ Episodic, unusual swollen belly after meals
- ☐ Vomiting blood
- ☐ Irritable bowel complaints
- ☐ Gluten allergy/ intolerance
- ☐ Dairy allergy/ intolerance
- ☐ Food allergies/ intolerances:
- ☐ Constipation
- ☐ Diarrhea
- ☐ OTHER

Geniourinary
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Abnormal prostate
- ☐ OTHER:

Heme/ Onc
- ☐ Abnormal bruising or bleeding
- ☐ Hypercoagulability/ blood clots
- ☐ Mass or lump
- ☐ OTHER

Neurological
- ☐ Seizure
- ☐ Stroke / Intracerebral hemorrhage
- ☐ Traumatic brain injury
- ☐ Balance problems
- ☐ Falling
- ☐ Attention Deficit or Learning Disorders
- ☐ Brain Fog
- ☐ Numbness/ tingling feet / legs or arms
- ☐ OTHER

Endocrine
- ☐ Diabetes Type I , II or “prediabetic”
- ☐ Complications of Diabetes
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid disorder
- ☐ Polyuria, polydyspnia
- ☐ Autonomic dysfunction
- ☐ Osteoporosis/ osteopenia
- ☐ OTHER

Infectious Disease
- ☐ History of MRSA
- ☐ Skin infection
- ☐ Bowel infection/ C- Diff
- ☐ Urinary tract infections
- ☐ Sinus/ respiratory infections
- ☐ Fevers/chills or night sweats
- ☐ Sexually transmitted disease
- ☐ OTHER:

Musculoskeletal/ Rheumatological
- ☐ Joint pain/ swelling – where & when:
- ☐ Muscle ache/ pain
- ☐ Tendonitis/ bursitis
- ☐ Low back pain
- ☐ Neck pain
- ☐ Thoracic pain
- ☐ Scoliosis
- ☐ Fractures
- ☐ Upper limb pain/ impairment:
- ☐ Lower limb pain/impairment:
- ☐ Weakness of limb
- ☐ Morning stiffness – how many minutes?
- ☐ Change in color hand/ feet in cold
- ☐ OTHER:

Skin & Hair
- ☐ Recent hair loss
- ☐ Rashes
- ☐ Itching
- ☐ Moles
- ☐ OTHER:

Mental Health
- ☐ Memory changes
- ☐ Episodes of confusion
- ☐ Mental health diagnosis
- ☐ Substance abuse
- ☐ Anxiety, depression, anger issues
- ☐ OTHER

Gynecological/ Breast
- ☐ Breast mass, discharge
- ☐ Spontaneous abortions
- ☐ Vaginal bleeding
- ☐ Irregular/ heavy periods
- ☐ OTHER:

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Patient Name: _____

YOUR PERSONAL GOALS

Please list for us your personal pain, physical or fitness goals, in order of importance. Examples might be to train for a specific job, be able to stand to prepare a whole meal, play tennis with your partner, walk a mile, run a 5 K, sleep through the night, etc. We want to know what outcomes would make you happiest with your results of treatment:

1. _____
2. _____
3. _____
4. _____

ANY OTHER INFORMATION YOU WOULD LIKE US TO HAVE and CONSIDER?

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IO

Notice of Privacy Practice / HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY and SIGN ON THE LAST PAGE.

This notice describes our privacy practices. We are required by law to protect the confidentiality of your medical information; provide you with this notice of our legal duties and privacy practices; and abide by the terms of our current notice of privacy practices. We may change this notice and our privacy policies at any time and have the revised notice and policies apply to all the protected health information we maintain. If we change our notice, we will post the new notice in our office where it can be seen. You have the right to request at any time a paper copy of our current notice, even if you have agreed to receive this notice electronically.

How the Practice May Use or Disclose Your Health Information

1. For Treatment We may use and disclose your health information to those involved in your treatment. For example, your information may be used by or disclosed to a physician or other health care provider in this practice. Because your physician in this practice is a specialist, we may request that your primary care physician share your health information with us, and we may provide your primary care physician with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. We may also provide your information to laboratories, pharmacists, and other outside providers involved in your treatment.
2. For Payment We may use and disclose your health information to others for purposes of billing and collecting payment for treatment and services that we provide to you. For example, we may submit a bill to you or a third-party who is financially responsible for your treatment, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and the treatment or supplies used in the course of treatment. We may also disclose your health information to other health care providers to assist in their billing and collection efforts.
3. For Health Care Operations We may use and disclose your health information to perform activities that support this practice, such as cost-management and business planning activities, and activities that ensure the delivery of quality care. For example, we may engage the services of a professional (such as an accountant, auditor, or attorney) to assist us with compliance-related activities. If we do so, these professionals may review billing and medical files. We may also ask quality improvement personnel t review our charts and medical records to evaluate the performance of our staff. We may also disclose your health information to other health care providers to assist in their health care operations.

Disclosures That Can Be Made Without Your Authorization. There are situations in which we are permitted to disclose or use your health information without your authorization and without providing you with an opportunity to object. Provided below are descriptions of such situations.

- Public Health, Abuse or Neglect, and Health Oversight We may disclose your health information to certain public health authorities (such as local and state health department s and the Centers for Disease Control and Prevention) that are authorized by law to collect information for purposes of reporting information about disease or injury; reporting vital statistics; investigating the occurrence and cause of injury and disease; and monitoring adverse outcomes related to food, drugs, biological products, or medical devices. For example, if authorized by law, we may disclose health information about a patient to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may also disclose a patient's health information to report reactions to medications, report problems with products, or notify people of recalls of products they may be using. We may also disclose your health information to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- Illinois law requires physicians to report child abuse or neglect. Illinois law also requires physicians who have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report that information to the state. We are permitted to disclose health information about a patient to a public agency authorized to receive reports of child abuse or neglect and to disclose information about a patient to report abuse or neglect of elders or the disabled.
- We may disclose your health information to a health oversight agency in connection with certain "oversight activities" authorized by law. Examples of these activities include audits; investigations; inspections; surveys' licensure and disciplinary actions; administrative, civil, and criminal actions or proceedings; and other activities necessary for the government to monitor government programs, the health care system, and compliance with civil rights laws.

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HIPAA Privacy Policy, continued

Disclosures Required by Law: We may disclose information about you when disclosure is required by law.

1. Legal Proceedings /Law Enforcement We may disclose a patient's health information in the course of judicial or administrative proceedings in response to an order of a court (or an administrative decision-maker) or other appropriate legal process. Certain requirements must be met before we disclose your information under these circumstances. We may also disclose a patient's information if asked to do so by a law enforcement official if the information: (a) is released pursuant to legal process, such as a warrant or subpoena; (b) pertains to a victim of crime and the patient is incapacitated; (c) pertains to a person who has died under circumstances that may be related to criminal conduct; (d) is about a victim of crime, and we are unable to obtain the person's consent; (e) is released because of a crime that has occurred on our premises; or (f) is released to locate a fugitive, missing person, or suspect. We also may release a patient's information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.
2. Workers' Compensation We may use or disclose your health information in order to comply with laws and regulations related to workers' compensation and similar programs.
3. Decedents We may disclose a deceased patient's health information to (a) a funeral director when such disclosure is necessary for the director to carry out his or her lawful duties; (b) to a coroner or medical examiner to identify a deceased person or a cause of death; and (c) an organ procurement organization for cadaveric organ, eye, or tissue donation purposes, if the patient is a donor.
4. Research We may use or disclose your health information for research purposes when an institutional review board or privacy board has reviewed the research project, approved the research, and established protocols to ensure the privacy of your health information. We may also use a patient's health information in connection with certain activities preparatory to research and in connection with research on the protected health information of decedents.
5. Government Functions If you are in the military, we may disclose your health information to appropriate military command officers upon request. We may also disclose your information to federal officials (a) for national security and intelligence activities authorized by law and (b) for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.
6. Inmates If a patient or other individual is an inmate or under the custody of a law enforcement official, we may disclose that person's health information to correctional institutions or law enforcement officials if the information is necessary to allow the institution to provide that person with medical care, to protect the health or safety of that person or others, or to maintain the safety, security, and good order of the institution.

Your Rights: You have the following rights regarding the protected health information maintained by this practice:

1. Requested Restrictions You have the right to request that we restrict or limit how we use or disclose your protected health information for purposes of treatment, payment, or health care operations. You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care. We do NOT have to agree to the requested restrictions, but if we do agree, we will comply with your request except under emergency circumstances or when otherwise required by law to use or disclose your information in violation of your request. To request a restriction, please submit the following information in writing: (a) the information to be restricted; (b) what kind of restriction you are requesting (for example, on the use of information, disclosure of information, or both); and (c) to whom the restrictions apply. Please send the request to our Privacy Officer at the address provided at the end of this notice. You do not need to provide us with the reason for your request.
2. Confidential Communications You have the right to request that we communicate with you about your health and related issues by alternative means or at an alternative location. For example, you may request that we contact you at work rather than at home. We are required to accommodate only *reasonable* requests. To request a restriction, please submit the following information in writing: exactly how you want us to communicate with you and, if you are directing us to send communications to a particular place, the contact/address information. Please send the request to our Privacy Officer at the address provided at the end of this notice. You do not need to provide us with the reason for your request.
3. Inspection and Copies of Protected Health Information You have the right to inspect and/or receive copies of your health information that is maintained by this practice. Texas law requires that requests for copies be made in writing. We ask that requests for inspection of your health information also be made in writing. Please send your request to our Privacy Officer at the address provided at the end of this notice. We may ask that a narrative of your health information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We are also permitted to refuse to provide some of the information you ask to inspect or be copied if the information: (a) is psychotherapy notes; (b) reveals the identity of a person who provided information under a promise of confidentiality; (c) is subject to the Clinical Laboratory Improvements Amendments of 1988; or (d) has been compiled in anticipation of litigation. We are

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HIPAA Privacy Policy, continued

also permitted to refuse to provide access to or copies of your health information in other limited situations, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the decision to deny access. Illinois law requires us to be ready to provide copies or a narrative of your health information within 15 business days of your request or, in many situations, within 15 business days of receipt of payment for such copies. We will inform you when your records are ready or if we believe access should be limited. If we deny access, we will inform you of our decision in writing. We are, under most situations, permitted to charge a reasonable fee for providing copies of medical records.

4. Amendment of Health Information You have the right to request an amendment of your health information maintained by this practice. Any such request must be submitted in writing to our Privacy Officer and must include the reason(s) that support your request for amendment. We will respond within 60 days of your request. We will deny your request if you fail to submit the request in writing (and/or include the reason(s) supporting your request). Additionally, we may refuse to allow an amendment if, in our opinion, the information in question is: (a) was not created by our practice, unless you supply us with a reasonable basis to believe that the person or entity that created the record is not available to amend the record; (b) is not part of our designated record set; (c) is not part of the records you would be permitted to inspect or obtain copies; or (d) is accurate and complete. If we refuse to allow an amendment, we will inform you in writing. If we deny your request, you are permitted to include a statement about the information at issue in your medical records. If we approve the request, we will inform you in writing; will allow the amendment to be made; and, upon a request from you t do so, will notify the relevant persons and entities named in your request with which the amendment needs to be shared.
5. Accounting of Certain Disclosures You have the right to request an accounting of disclosures made by this practice for purposes other than for treatment, payment, or health care operations, made pursuant to an authorization signed by you or your representative; or made to you or your representative. Please submit any request for an accounting to our Privacy Officer at the address provided at the end of this notice. In your request, specify the time period for which you are requesting an accounting (which may not be longer than six years from the date of disclosure. Your first accounting of disclosures within a 12-month period will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Benefits We may contact you by telephone, mail, or both, to provide appointment reminders, information about treatment alternatives, or other health-related benefits or services. If we contact you by telephone and no one answers the call, it is our practice to leave a message on the telephone answering machine. If we contact you by mail, we may use a postcard instead of a sealed envelope.

Complaints If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer at the address provided at the end of this notice. We request that all complaints be submitted in writing. You may also send a written complaint to the Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

Patient Authorization We will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law. If you choose to sign an authorization, you can later revoke that authorization in writing, to stop future uses and disclosures; however, any revocation will not apply to disclosures or uses already made or to disclosures made in reliance on your prior authorization.

Contact Information If you have any questions or complaints, or if you want to make a request pursuant to any of the rights described above, please contact our Privacy Officer at 737 North Michigan Avenue, Suite 960 Chicago, IL 60611 312-926-1600

I have reviewed Global Health Partner's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____. _____ _____

Patient (or representative) NAME (please print) | Today's date | Patient (or representative) signature