LAKE BARRINGTON WOMEN'S HEALTH CENTER, P.C.

22285 Pepper Road, Ste 111
Barrington, Illinois 60010
847 382-7330

284B Memorial Court
Crystal lake, Illinois 60014
815-893-0700

PRIVACY NOTICE
(As required by Federal Regulations)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Treatment
I hereby give my consent and authorize the above named practice to examine me and render any necessary medical testing or treatment for my health and well-being.

Payment
I understand that this practice will file claims with my medical insurance carrier(s). I hereby give my consent and authorize this practice to release any information acquired in the course of my examination and treatment to my insurance company(ies) pertinent to billing. I recognize that the information may include facts about drug/alcohol use, mental health, sexually transmitted diseases, and/or HIV/AIDs testing. I authorize the release of any information pertinent to my case to my insurance company, adjuster or attorney involved in my case.

I hereby authorize my insurance company(ies) to pay this practice for any professional/medical expense benefits allowable and payable under my current insurance policy(ies) as payment toward the charges for services rendered. I agree to pay, in a timely manner, any balance not covered by my insurance.

Health Care Operations
I also understand there are other instances when disclosure will be necessary on my behalf when ordering diagnostic/screening tests, prescription drugs, hospitalization, or physical studies; or when referring me to another physician for consultation or surgery, or my primary care physician requests the findings; or when my insurance company conducts a particular health study. I hereby give my consent and authorize the release of the necessary information in such cases.

Additionally, I understand that I may revoke this authorization in part or in whole at anytime by written instruction to this practice.

Legal Requirements
This practice is required by law to maintain and protect the privacy of your individual health information. We are committed to your health and well-being as well as your individual privacy and rights as stated in this Patient Rights and Privacy Notice.

This medical practice reserves the right to amend this Privacy Notice as the need arises. Any amendments to the Privacy Notice will be posted in the office reception areas.

Patient Rights
As a patient of this practice, you have the right to:

- Request restrictions on certain uses and disclosures.
- Receive confidential communications from this practice.
- Inspect your protected health information and to receive a copy of the same for a copying fee ranging from $20 to $50, depending upon the size of your patient chart.
- Amend any incomplete or incorrect protected health information by discussing the problem with your physician.
- Register a complaint with this practice by calling either your personal physician or the Office Manager or by contacting the Department of Health and Human Services.

If you want to correct, amend or place restrictions on your chart information, or ask questions about this Notice, call the Office Manager at (847) 382-7330.

I have read and understand this Notice.

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Signature of Patient or Legal Guardian **Date**