

PATIENT'S INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	LAST NAME	FIRST NAME	MIDDLE		
LEGAL GENDER PER INSURANCE	<input type="checkbox"/> Male <input type="checkbox"/> Female	GENDER IDENTITY	<input type="checkbox"/> Cis-Gender <input type="checkbox"/> Non-Gender <input type="checkbox"/> Gender Fluid <input type="checkbox"/> Trans-Gender	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
SOCIAL SECURITY #	DATE OF BIRTH:	PHONE #:	EMAIL ADDRESS:		
HOME ADDRESS:	APT #:	CITY:	STATE:	ZIP:	
EMPLOYER:	CITY:	STATE:	ZIP:		
EMERGENCY CONTACT PERSON(S):	CONTACT #:	RELATION:			
PREFERRED COMMUNICATION:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL	<input type="checkbox"/> WORK	<input type="checkbox"/> EMAIL	<input type="checkbox"/> MAIL

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

POLICY HOLDER'S NAME:		
INSURANCE CO.:		
POLICY #:		
GROUP NAME #:		

*IF THE PERSON INSURED IS DIFFERENT FROM THE GUARANTOR, PLEASE PROVIDE THE INFORMATION BELOW SO WE CAN ASSIST YOU IN FILING YOUR MEDICAL CLAIM.

GUARANTOR INFORMATION (Person who pays for the insurance policy / Insurance holder)

NAME:	RELATIONSHIP:	DOB:	SSN:	
HOME ADDRESS:	APT #:	CITY:	STATE:	ZIP:
EMPLOYER:	CITY:	STATE:	ZIP:	
OCCUPATION:	CELL #	WORK #	EMAIL:	

- ☐ I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. I RELEASE YOU FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED.
- ☐ I DO NOT AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. IN DOING SO I AM RESPONSIBLE FOR MY MEDICAL BILLS.

Signature of Patient/Legally Authorized Representative

Date



EXHALE SINUS
TMJ | HEADACHE | SLEEP

814 E Woodfield Rd.
Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332
info@exhalesinus.com

PATIENT REGISTRATION

PATIENT HEALTH HISTORY

PATIENT NAME:	DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT:
HOME PHONE:	WORK PHONE:	DO YOU HAVE A FEAR OF NEEDLES?: <input type="checkbox"/> YES		
RETAIL PHARMACY:	PHONE:	ADDRESS:		
MAIL ORDER PHARMACY:	PHONE:			
REASONS FOR THIS VISIT:		HOW DID YOU HEAR ABOUT US?:		
PLEASE LIST THE NAMES OF ALL PHYSICIANS YOU CURRENTLY SEE (INCLUDE SPECIALTY AND CITY OF PRACTICE):				

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING DOSE AND HOW OFTEN YOU TAKE IT)

PLEASE LIST ALL **OVER THE COUNTER MEDICATIONS** (EXAMPLES: Tylenol, Advil) **HERBAL SUPPLEMENTS AND VITAMINS** YOU CURRENTLY TAKE.

ALLERGIES:

PREVIOUS MEDICAL HISTORY:

CHECK IF YOU OR ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING:

	MYSELF	FAMILY	RELATIONSHIP TO YOU
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	
MALIGNANCY/CANCER	<input type="checkbox"/>	<input type="checkbox"/>	
BLEEDING TENDENCY	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU SMOKE/HOW OFTEN?			
DO YOU USE ALCOHOL/HOW OFTEN?			

LIST ANY SURGERIES:

LIST OTHER ILLNESSES:

REVIEW OF SYSTEMS:

CHECK IF YOU HAVE ANY OF THE FOLLOWING:

FATIGUE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
VISION CHANGE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHEST PAIN / PALPATIONS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SHORTNESS OF BREATH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DIGESTIVE PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
URINARY DIFFICULTIES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MUSCLE OR JOINT PAINS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHANGES IN SKIN	<input type="checkbox"/> YES	<input type="checkbox"/> NO
EASY BRUISING OR BLEEDING	<input type="checkbox"/> YES	<input type="checkbox"/> NO
UNINTENTIONAL WEIGHT LOSS OR GAIN	<input type="checkbox"/> YES	<input type="checkbox"/> NO
FEELINGS OF DEPRESSED MOOD	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEARING CHANGES	<input type="checkbox"/> YES	<input type="checkbox"/> NO

IS THERE A FAMILY HISTORY OF HEARING LOSS? ☐ YES ☐ NO

HAVE YOU EVER HAD AN AUDIOGRAM (HEARING TEST)? ☐ YES ☐ NO



CONSENT FOR MEDICAL CARE AND TREATMENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS.

AUTHORIZATION FOR TREATMENT. I hereby voluntarily consent to such medical evaluation, treatment, services, and procedures as deemed necessary and appropriate for my condition based on the judgment of my doctor, his consultants, associates assistants, designee(s) and others in professional training programs ("health care providers").

NO GUARANTEE. I acknowledge that the practice of medicine is not an exact science and the health care providers have not made any guarantees or warranties as to the result of treatments or examination.

ILLINOIS INFECTIOUS DISEASE TESTING ACT. I understand and acknowledge that Illinois law provides if any health care worker is directly exposed to my blood or other bodily fluid, the healthcare provider(s) may perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Exhale Sinus and Facial Pain Center ("ESFPC").

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of ESFPC's Notice of Privacy Practices, which provides detailed information about how ESFPC and others listed in the Notice may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

RELEASE OF MEDICAL RECORDS. ESFPC or other healthcare providers who may treat me may use and disclose my health information for treatment, payment and health care operations without my specific authorization. ESFPC may share my medical information in any format it determines is appropriate to coordinate and seek payment for my care and to comply with public health reporting requirements. The information may be shared verbally, via fax, on paper, or through electronic health information exchanges.

SPECIFIC RELEASE FOR MENTAL HEALTH, SUBSTANCE ABUSE OR HIV INFORMATION. I specifically authorize ESFPC and its health care providers to release any and all information regarding mental health, substance abuse or HIV related diseases contained in my past or current record for the purposes stated in the above paragraph. I agree that the specific consent contained in this paragraph shall apply even if I am diagnosed and/or with one of the above conditions after I signed this consent.

FINANCIAL OBLIGATIONS

RESPONSIBILITY FOR PAYMENT. In consideration for services to be rendered, I agree to pay ESFPC for all services, facilities, and supplies provided to me at the established rates, including any deductible, co-payment, co-insurance or charges not covered by my insurance carrier or third party payers. I accept the responsibility for any costs, including attorney fees incurred in the collection of these charges. Furthermore, I acknowledge receipt of ESFPC's Insurance & Financial Responsibility Agreement.

INITIAL _____

I understand that if I do not consent to the release medical records to my insurance carrier or third-party payers, I am fully responsible for payment for all charges for treatment received, if such refusal results in the denial of payment. I certify that the information given by me for purposes of payment is, to the best of my knowledge, complete and accurate.

INITIAL _____

MEDICAID. ESFPC is a non-participating Medicaid provider. In the event I am a Medicaid patient, I fully understand that I am responsible for paying ESFPC for all services provided to me.

INSURANCE DISPUTES. If there is a dispute regarding the payment of my insurance or certain workers' compensation claim, I authorize ESFPC to bill me prior to the resolution of that dispute and I agree to pay those amounts.

COMMUNICATIONS

CONTACT AUTHORIZATION. I authorize ESFPC to contact me via telephone call, voicemail, email or SMS text messages to provide medical and/or financial information, including but not limited to, appointments, payment reminders, and delinquent notifications. I understand, and acknowledge, that my patient information may appear in the email or text. In order for ESFPC to collect any amounts I may owe, I expressly agree and consent that ESFPC or its designated collection agents may contact me by telephone at any telephone number I provide, or any telephone number that the collection agents obtain or, at any number forwarded or transferred from that number, regarding the services rendered, or any related financial obligations. Methods of contact may include pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

I understand that if information is emailed to me, there may be some level of risk that this information could be read by an unauthorized party. By providing my e-mail address, I am accepting the risks and authorizing ESFPC and its health care providers to communicate with me electronically about my care, account, services, and/or education.

Email: _____

Home Number: _____

Cell Number: _____

Other: _____

I hereby give authorization to ESFPC and its health care providers to discuss my medical condition, including laboratory and diagnostic test results, and/or financial information with the following:

- a. _____ Relationship _____ Phone _____
NAME
- b. _____ Relationship _____ Phone _____
NAME
- c. _____ Relationship _____ Phone _____
NAME

PRESCRIPTIONS

ESFPC continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians and pharmacists. ESFPC electronic health record (EHR) provides secure access for patients with commercial prescription coverage in the United States.

Prescription eligibility, benefit, formulary and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings.

I consent to electronic prescriptions and acknowledge that ESFPC will use electronic connectivity between payers, physicians and pharmacists.

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

I UNDERSTAND THIS CONSENT MAY BE REVOKED IN WRITING BY ME AT ANY TIME, EXCEPT TO THE EXTENT ACTIONS WERE TAKEN PRIOR TO THE REVOCATION OF CONSENT.

NOTE: THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE DATE OF SIGNATURE.

Signature of Patient/Legally Authorized Representative

Date



INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to Exhale Sinus and Facial Pain Center ("ESFPC"). We believe you deserve the best care. That's why we strive to provide you with the best medical care possible to treat your personal situation. Each year, we provide medical care to hundreds of patients. Some of these patients have medical benefits while others do not. If you have medical benefits, congratulations! You are very fortunate. Below are some important things you should know. Please read this Agreement carefully, initial each section, and sign and date at the bottom.

INITIAL:

- _____ Your medical benefits are based upon a contract made between you or your employer and an insurance company. If you have any questions regarding your medical benefits, please contact your employer or insurance company directly. Most medical benefit plans will never pay 100% of your medical care. It is only meant to assist you.
- _____ We will bill your insurance as a courtesy. If insurance does not pay within 45 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU and your insurance company**. ESFPC is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred by ESFPC. Any delinquency on your account will result in a \$25 monthly late fee added to the account. In the event that we incur any expense in the collection of your account, expenses for collections agencies or court costs will be applied to your account.
- _____ We currently accept all private pay, and most of the major commercial health insurance plans. This means that we work with many insurance companies. It is your responsibility to know if ESFPC is in-network and recognized by your insurance plan. Although we can maintain a computerized history of payments by a given company, they change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-authorization" with your insurance company prior to treatment. Keep in mind that this is still not a guarantee of coverage. A pre-authorization may delay treatment, but it will give you the best estimate of your out-of-pocket expenses.
- _____ It is **your responsibility** to know if your insurance has any deductibles, co-payments, age limits, exclusions, waiting periods, clauses or any other type of benefit limitation for the services received. Many times, these exclusions are provided to employees only and are not made available to our staff when confirming benefits. As a result, we can only estimate based on what your insurance discloses to us.
- _____ We require payment in full for your estimated portion at the time of service. We accept all major credit cards, cash and checks. If your check payment has insufficient funds and is returned to us, there will be a \$25 fee. Any discount you may have at the time of service will be revoked, and your future payment must be in cash, credit or debit card.
- _____ A specific amount of time is reserved, especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least 24 hours notice** to avoid a \$65 cancellation fee for an office visit and a \$500 cancellation fee for procedures or surgery. **(Emergencies are an exception)**.

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ THIS AGREEMENT AND THE AGREEMENT HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

Signature of Patient/Legally Authorized Representative

Date



EXHALE SINUS

TMJ | HEADACHE | SLEEP

814 E. Woodfield Rd.
Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332

PATIENT REGISTRATION

CHECK IN PROCESS:

1. Insurance card and a valid ID are required during the check in process for every visit.
2. A Patient/Parent/Guardian must notify the office of changes in address, telephone number or insurance.
3. You are required to pay your past due balance or balances.
4. You will be responsible for payment for charges of services rendered if we are unable to verify benefits.
5. We accept cash, checks, Visa, MasterCard, American Express, and Discover. (Payment is due at time of service.)
6. Insurance companies require a collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not been met, you will be required to pay for the visit at the contractual rate. If your insurance does not pay for a service, the charges will be the responsibility of the Patient/Parent/Guardian. We recommend that you always question your insurance company regarding your benefits and do not assume that everything done in our office is covered by your insurance carrier.

APPOINTMENTS:

1. You must arrive 10-15 minutes prior to your appointment.
2. Rescheduling may be necessary if you are late for your appointment. We will try our best to work you in if time allows.
3. Appointment canceled with less than 24 hours in advance of your appointment will be billed with the following fees: \$65.00 fee for a canceled office visit and \$500 fee for a canceled procedure or surgery.

FINANCIAL RESPONSIBILITIES:

1. ALL DUE BALANCES MUST BE PAID PRIOR TO BEING SEEN, unless you have made a financial arrangement with our office (with the exception of emergency visits).
2. NO EXCEPTION for the following: Deductibles and Copay must be collected at the time of service.
3. Private Pay Patient appointments require a \$100 deposit. This will be applied to your final bill. This is non-refundable if you cancel your appointment with less than 24 hours in advance.
4. There is a \$25.00 fee for returned checks.

MEDICATION REFILLS:

1. Medication refills may be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e. allergies, rhinitis, etc.). Please note if you are out of refills, you may be due for a follow up appointment. Refills will not be provided after hours or on the weekends. Please allow 72 hours for these refills to be completed.
2. Antibiotics will not be prescribed over the phone. If you feel you may need an antibiotic, you will need to be seen.
3. Narcotics and controlled substances cannot be called in. Patient **MUST** see the Doctor for an appointment to discuss these medications.

OTHERS:

1. Medical records can be faxed to another physician free of charge for continuum of care and upon receipt of the medical records release.
2. Patients may obtain a copy of their medical record for a fee. Our office will provide patients their medical record in a form of a USB flash drive. Patients may also request paper copies; however, an additional fee may apply.
3. An excused absence for school or work will only be issued if you have been seen in the office for the illness. A note must be obtained at the time of visit.
4. Due to HIPAA laws, patients must check in with the receptionist and are not allowed in the back office without consent.
5. All telephone calls made to ESFPC for issues that normally necessitate an office visit, including but not limited to requesting medical advice or consultation, will be charged between \$20 and \$60 per call, depending on the length of the call. These calls may or may not be covered by your insurance and may result in additional payment due. You agree to pay all fees which are not covered by your insurance.

ACKNOWLEDGEMENT

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Signature of Patient/Legally Authorized Representative

Date



EXHALE SINUS

TMJ | HEADACHE | SLEEP

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Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332

OFFICE FINANCIAL POLICY

INSURANCE There are numerous insurance networks in the Chicago land market. Our providers are not part of all these networks and therefore, they have not agreed to accept a reduced fee from all insurance companies.

Insurance coverage is a contract between the patient and the insurance carrier, it is the responsibility of the patient/guardian to know and understand the benefits of his/her particular insurance plan, and whether or not physician is in net- work. We will file claims with insurance and by law, the insurance carrier must remit payment or deny the insurance claim within 30 days of initial notice. Not all insurance plans cover all services and in the event your insurance plan determines a services to be "not covered", the patient will be responsible for the complete charge. If insurance problem occur, we will bill the patient and the patient may be asked to assist the office in contacting the carrier and/or in filing a complaint with the State Insurance Commissioner.

PAYMENT:

1. If our physician is **contracted with your insurance plan, we are required to collect the co-payment at the time of service.** If our physician is not contracted with your insurance plan, **you are required to remit full payment at the time of visit.**
2. We have the capability to perform cost of care at the time of service to determine the patient responsibility based on the insurance plan. It is our policy to collect any deductible, co-insurance and/or non-covered charges at this time.
3. **Fees for any procedures are not included with the office exam and may be applied to your deductible or co-insurance.**
4. **SELF PAY patients only:** All procedures are subject to an additional charge. _____ (Initial)
5. **When you or a family member provide us with a credit card number, you are giving us permission to use the card to pay the account balance. All credit card transactions are assessed a 3% transaction fee.**
6. Any questions concerning office financial policy or patient's need of assistance should be directed to the billing specialists or practice manager immediately.
7. All patients will be required to establish financial arrangements for payment of their account.
8. Accounts that have an outstanding balance for over 90 days may be forwarded to an outside collection agency and, 18% service fee will be added to the account. The patient is responsible for the entire balance including, the 18% fee.
9. Our physician accepts Medicare assignment. Medicare part B has **a calendar year deductible and a 20% co-insurance.** All secondary insurances may or may not cover your Medicare annual deductible. Patient is responsible for this balance.

CANCELLATION/OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a missed appointment fee. Office visit: \$65 Allergy Testing: \$100 Botox Testing: \$100 and Procedure/Surgery: \$500 must cancel 2 weeks before your scheduled date. _____ (Initial)

Cost of Care (COC) Estimate: Will be collected at your pre-op appointment or within one week before your procedure. _____ (Initial)

Procedure CPT Code Denials: If for any reason your insurance denies any procedure codes even after receiving an authorization, it is the patient responsibility for any balance/charge. _____ (Initial)

SELF PAY: At the time an appointment is scheduled, the patient will need to pay a \$100 appointment deposit to secure the scheduled appointment. This is a non-refundable amount if the appointment is canceled in less than 24 hours of the scheduled appointment and/or you miss the appointment. A full payment is required at the time of the visit, for all services provided on the day of appointment. _____ (Initial)

I have read this policy and hereby authorize my insurance benefits to be paid directly to the physicians office, realizing that I am responsible to pay non-covered service. I further authorize the release of pertinent medical information to my insurance carriers.

Patient or Guardian's signature: _____ **Date:** _____



SNOT-22

Please rate the severity of your sinus or nasal problems	No problem	Very Mild Problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be	Total Score
1. Need to blow your nose	0	1	2	3	4	5	
2. Sneezing	0	1	2	3	4	5	
3. Runny nose	0	1	2	3	4	5	
4. Cough	0	1	2	3	4	5	
5. Post-nasal discharge or dripping in your throat	0	1	2	3	4	5	
6. Thick nasal discharge	0	1	2	3	4	5	
7. Ear fullness	0	1	2	3	4	5	
8. Dizziness	0	1	2	3	4	5	
9. Ear pain/pressure	0	1	2	3	4	5	
10. Facial pain/pressure	0	1	2	3	4	5	
11. Difficulty falling asleep	0	1	2	3	4	5	
12. Waking up at night	0	1	2	3	4	5	
13. Lack of a good night's sleep	0	1	2	3	4	5	
14. Waking up tired	0	1	2	3	4	5	
15. Fatigue during the day	0	1	2	3	4	5	
16. Reduced productivity	0	1	2	3	4	5	
17. Reduced concentration	0	1	2	3	4	5	
18. Frustrated, restless, or irritable	0	1	2	3	4	5	
19. Sadness	0	1	2	3	4	5	
20. Embarrassed	0	1	2	3	4	5	
21. Loss of taste or smell	0	1	2	3	4	5	
22. Blockage/congestion of nose	0	1	2	3	4	5	
Total Score							110



EXHALE SINUS

TMJ | HEADACHE | SLEEP

PHQ-9

Name: _____ DOB: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

TOTAL SCORE: _____



EXHALE SINUS

TMJ | HEADACHE | SLEEP

GAD-7

Name: _____ DOB: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

TOTAL SCORE: _____



NOTICE OF PRIVACY PRACTICES

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.

This center creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an acknowledgement that you received this notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called “protected health information” or “PHI.” We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain private health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: We do not engage in fundraising activities. We do not engage in marketing activities, and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (773) 234-5880. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations), You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website at www.exhalesinus.com, or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

Patient Signature

EFFECTIVE DATE: _____

(rev 3/2020)