ROSALIND FRANKLIN UNIVERSITY
HealthClinics

Welcome, our Rosalind Franklin University Health Clinic's would like to thank you for your inquiry into Reproductive Medicine and Immunology. We are committed to a complete understanding of the role of the immune system in pregnancy and using this knowledge to help infertile couples achieve a successful pregnancy.

Our mission is to understand and advance the study and treatment of the immunological aspects of the reproductive process. While attempting pregnancy, we co-manage you with your reproductive endocrinologist, primary gynecologist, obstetrician, and other provider(s) that may be caring for you. Once pregnancy occurs, we co-manage your treatment plans with your obstetrician.

Dr. Joanne Kwak-Kim (MD) has gained international recognition as an authority in the field of reproductive immunology. Her expert understanding of the role of the immune system in pregnancy and pregnancy loss has helped thousands of patients.

Please read and complete the enclosed packet in its entirety. After we received the initially required forms, and activate your patient portal within Athena, you will be contacted to set up an initial appointment. This appointment may consist of a physician consultation, blood tests, or ultrasound evaluation, depending on your needs assessment. Once initial evaluations are completed, you will be contacted regarding follow-up treatment and planning. In addition, all information will be forwarded to your referring physician, as indicated by you.

Treatment protocols are often a combination of physician services and ancillary services. To the best of our ability, we will inform you of the planned treatment after the initial evaluation. However, it may be necessary to change the treatment protocol as a result of changes during treatment. The following is a list, not inclusive, of many of the common services that you will receive and be billed for while receiving treatment.

- Physician Visit or Consultation or procedures
- Physician or Nurse Phone Consultation
- Physician Interpretation of Tests
- Physician Medical Records Review
- Supervision of Home Care Services
- Ultrasound Scans
- Laboratory Tests

We will bill any in-network insurance for professional services received at Rosalind Franklin University Health Clinics. You will receive a separate invoice for labs processed by Clinical Immunology Laboratory at Rosalind Franklin University of Medicine and Science, or external lab as deemed in-network by your insurance (i.e. Quest or LabCorp). The Reproductive Immunology Team is committed to providing services in good faith and with the understanding that in the event your insurance coverage is not current or valid, is different than what was provided during patient registration, or your insurance plan has denied claims/payment, you will be balance billed and are financially responsible for all products and services rendered.

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The Rosalind Franklin Health Clinic's Reproductive Medicine and Immunology Program is excited to inform you that we have received your request for a New Patient appointment and have added you to our appointment scheduling list. Currently, our Reproductive Medicine and Immunology program is scheduling with limited availability and we will prioritize all New Patient scheduling requests based upon provider availability and your timely submission of all required health forms.

Local patients who are within a 2-hour driving distance to our clinic will be scheduled for follow-up visits to be seen in person within our clinic. Telehealth/telephone consults will be limited to those patients outside of this travel area. Prior to our team being able to schedule your first appointments, there are critical steps which you must complete to ensure accuracy in the registration process.

These steps must be completed prior to scheduling your first appointments and include:

- **Complete the "New Reproductive Patient Intake Form"**: This form is located attached to this welcome packet. Please download, print, and complete the form in its ***Entirety***.
- **Complete the RFU HC Annual Consent form**: Located within the patient portal under My Health and Medical Forms.
- **Complete your registration within the Athena Patient Portal**: At the time of your call, we will provide you with an invitation to activate your patient portal, this may be sent to the e-mail you provided. The Athena patient portal is a HIPAA compliant bi-directional communication tool that our practice utilizes for secure patient communication. You may download forms to complete, scan, and upload these to your portal.
  - You can locate these forms under the My Health Tab on the left side of the home page, then select Medical Forms.
  - Please download these forms, print, and complete. Please then scan and upload these forms directly under the "Health Records Tab". ***Note: If you have not had an appointment, this option is not available thru Athena. Please fax, mail, or bring these forms into the clinic.***
- **Upload a copy of your current insurance(s) and identification**: You may upload a copy through your patient portal; however, will need to bring a physical copy at the time of your visit.

Upon completion of the above steps, we will begin scheduling you for your appointments. Please note, your scheduled appointments will be reflected within your patient portal in live-time.

- **Additional History Review forms**: In addition to initial registration/scheduling forms listed above, we request that you submit your past 12 months of obstetrical/IVFand lab history (if available) from your external care team along with any current physician referral information. This additional history may be sent to the address listed below, via fax, or through the patient portal. If we do not receive your external medical records and history forms prior to your first visit, we may need to reschedule your visit for a later time.

****It is imperative that you submit the requested medical records from your extended care team. The RFU HC clinical team will review your records for thoroughness and will individualize your plan to only include the imaging and labs deemed necessary to tailor your plan of care. You may fax, mail, or utilize the patient portal to upload these forms. Please note: Until you are seen for your first visit, we will not be able to provide clinical or financial advice through the portal.***

We look forward to helping you along your journey to parenthood. If for whatever reason you are unable to keep your scheduled appointment, please immediately contact our front desk at (847) 247-6900. If we do not receive advanced notice, your priority will be adjusted on the wait list.

Rosalind Franklin University Health Clinics
Reproductive Medicine and Immunology
830 West End Court, Suite 400, Vernon Hills, IL 60061
Phone (847) 247-6900 Fax (847) 247-6951

Appointments and expectations:
For all patient's whose insurance is Out of Network and will be paying as self-pay, we will require a $5,000 deposit at time of your first visit to be applied to upcoming professional charges and to secure your priority on the wait list.

New Patient Appointments: Your first new patient appointments will consist of the following appointment types:

- **Ultrasound:** You will be seen by a member of our ultrasonography team to complete ordered imaging.
- **Laboratory**: You will need to complete all ordered laboratory tests*
- **Advanced Practice Provider (APP):** You will also be scheduled with one of our APP team members, who will review your medical history and will complete an exam.
- **Dr. Kwak-Kim and Dr. Than Luu:** Upon completion of the above appointments, you will be scheduled to meet with Dr. Kwak-Kim, who will review your history and discuss our Reproductive Immunology program in more detail.
- **Intake coordination:** You will be contacted by our Intake Coordinator, Laurie Behrendt, prior to your initial appointments. She will discuss the program, confirm your insurance and coverage needs, as well as provide you with a Good Faith Estimate for anticipated services, and any required forms that may be needed to seek reimbursement through your insurance.

Subsequent appointments:
You have also been scheduled for a follow-up consultation, approximately 3-4 weeks following your initial appointments with Dr. Kwak-Kim or Dr. Than Luu. During this appointment, Dr. Kwak-Kim or Dr. Than Luu will review and discuss your initial imaging and lab results.
Please remember the following instructions for your appointment(s):

1) **Fasting**: Ensure that you have nothing to eat or drink the night prior to your new patient appointment. This means no food or beverages for 8 hours prior to your scheduled appointment (water is ok). Upon completion of your labs, you may then have then resume normal intake (you can bring a snack with you and it is ok to drink water only).

2) **Full bladder**: To ensure that we are able to obtain adequate imaging for your ultrasound, you must have a full bladder when you arrive for your appointment. Please ensure that you drink a minimum of 32oz of water, 1 hour prior to your appointment and please don't use the washroom.

3) **Not to be on your menses:** In the event that you are actively on your menses, please immediately inform the front desk staff or the sonographer. The sonographer will discuss their ability to complete the ultrasound at that time. If the sonographer is unable to complete the ultrasounds, you will need to return to complete the ordered ultrasounds. The labs will still be completed and you will still be seen as indicated for your other appointments above (please disregard if your pregnant).

4) **It is strongly encouraged not to be in any planned conception cycles prior to seeing Dr. Kwak-Kim or Dr. Than Luu**

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REPRODUCTIVE MEDICINE AND IMMUNOLOGY PATIENT REGISTRATION

***The following information must be completed in its *ENTIRETY* prior to your first appointments. If we do not receive your requested history, you may be contacted to reschedule your appointment until these are received.**

PATIENT INFORMATION

Problems that led you to seek Reproductive Medicine and Immunology services (**Place and X by all that apply**)

	Recurrent Pregnancy Loss		Repeated IVF Failures
	Second/third trimester pregnancy loss		Poor ovarian response
	History of preterm delivery		Premature ovarian failure
	History of intrauterine growth restriction		Failed immunological treatment history
	Infertility of unknown etiology		
	Other (please list)		

Patient's Name: Last_____ First_____ MI_____

Date of Birth: _____ Today's Date: _____Email:_____

Address: _____ Apt./Suite#: _____

City: _____ State: _____ Zip: _____ Home Telephone: (_____) _____ Cell Phone: (_____) _____

Name of Employment: _____ Work Address: _____

City/State/Zip: _____ Work Phone: _____

Preferred Method of Contact: ❒ Home ❒ Cell ❒ Work ❒ Email: _____

Ethnicity: ❒ African American ❒Hispanic/Latino ❒ Caucasian ❒ Asian ❒ Other_____

Maternal Ethnicity: ❒ African American ❒Hispanic/Latino ❒ Caucasian ❒ Asian ❒ Other:_____

Paternal Ethnicity: ❒ African American ❒Hispanic/Latino ❒ Caucasian ❒ Asian ❒ Other:_____

Preferred Language: ❒ English ❒ Spanish ❒ Other: _____ Do you need an Interpreter? ❒ Yes ❒ No

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Preferred Pharmacy: _____
(Name) (Address)

_____
(Phone Number) (Fax Number)

Emergency Contact Name: _____ Phone: (_____) _____

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RESPONSIBLE PARTY (Please complete if different from patient or patient is a minor)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Address: _____ Apt./Suite#: _____

City: _____ State: _____ Zip: _____ Telephone: (_____) _____ E-mail: _____

Relation to Patient: ❒ Spouse ❒ Parent ❒ Grandparent ❒ Legal Guardian ❒ Other: _____

REFERRAL SOURCE(S)

❒ Friend/Patient
❒ Event/Health Fair
❒ Physician/Specialist
❒ Insurance directory
❒External Referral
❒Staff/Student
❒Current Patient
❒ Marketing (List): _____
❒ Website
❒ Social Media
❒ Other: _____

INSURANCE INFORMATION

Name of Policy Holder: _____ **Policy Identification Number:** _____

Primary Insurance: _____ **Group and Number:** _____

Primary Insurance Address: _____**Primary Insurance Phone:** _____

Name of Policy Holder: _____ **Policy Identification Number:** _____

Secondary Insurance: _____ Group **and Number:** _____

Secondary Insurance Address: _____**Primary Insurance Phone:** _____

PHARMACY INFORMATION

Pharmacy name: _____

Pharmacy Address: _____

_____

City State Zip Code

Pharmacy Phone: _____ Pharmacy **Fax:** _____

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SPOUSE/SIGNIFICANT OTHER INFORMATION

Patient's Name: Last_____ First_____ MI_____

Date of Birth: _____ Today's Date: _____

Address: _____ Apt./Suite#: _____

City: _____ State: _____ Zip: _____ Home Telephone: (_____) _____ Cell Phone: (_____) _____

Name of Employment: _____ Work Address: _____

City/State/Zip: _____ Work Phone: _____

Weight:_____ Height: _____ Blood Type (ABO/RH): _____ Race: _____

Spouse ethnicity:_____

OBSTERTICAL HISTORY

Currently Pregnant? ☐ Yes ☐ No Patient Age at time of first child: _____

At time of delivery was the child: ☐ Large ☐ Small **Have you breastfeed in the past** ☐ Yes ☐ No

History of *(If Other/Family, please indicate)

Anemia: ☐ No History ☐Patient

Atony: ☐ No History ☐Patient

Fetal/Neonatal Death/Anomaly: ☐ No History ☐Patient

Gestational Diabetes: ☐ No History ☐Patient

Hemorrhage: ☐ No History ☐Patient

Intrauterine Growth Restriction: ☐ No History ☐Patient

Postpartum depression: ☐ No History ☐Patient

Pregnancy Induced Hypertension: ☐ No History ☐Patient

Hyperemesis ☐ No History ☐Patient

Incompetent Cervix: ☐ No History ☐Patient

Chorioamnionitis: ☐ No History ☐Patient

PROM: ☐ No History ☐Patient

Vaginal Bleeding: ☐ No History ☐Patient

Preterm labor/Birth: ☐ No History ☐Patient

RH Negative Mother: ☐ No History ☐Patient

RH Sensitization: ☐ No History ☐Patient

Received Rhogam?: ☐ No History ☐Patient

GYNE History

Date of last menstrual period? _____ **Are menses normal?** ☐ Yes ☐ No

Do menses occur monthly? ☐Yes ☐ No **Frequency of cycles (In days)?** _____

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Flow rate? ☐ Light ☐ Moderate ☐ Heavy **Duration of flow (In days):** _____

Do you experience cramping with your period? ☐ Yes ☐No **Age of menarche:** _____

Date of last PAP:_____ **Was the PAP**: ☐Normal ☐Abnormal

Do you use Contraception? ☐Yes ☐No

Current Birth Control method (select):
☐None ☐ BCPs ☐ Sterilization ☐ Tubal ligation ☐ IUD ☐ Condom ☐ Partner vasectomy ☐ Depo-Provera
☐ Vaginal ring ☐ Hysterectomy ☐ Abstinence ☐ Diaphragm ☐ Seeking Pregnancy ☐ Implant ☐ Patch ☐ Sponge
☐ Menopause ☐ Spermicide ☐ Pregnant ☐ Ablation ☐ Fertility issues ☐ Breastfeeding/LAM
☐ Emergency contraception ☐ Cervical Cap ☐ Other: _____

History of Adenomyosis? ☐Yes ☐ No **History of Endometriosis?** ☐ Yes ☐ No

History of Pelvic inflammatory disease? ☐ Yes ☐ No **Uterine anomaly?** ☐ Yes ☐ No

History of Sexually transmitted disease? ☐ Yes ☐ No **Uterine fibroid?** ☐Yes ☐ No

Sexual problems? ☐Yes ☐No **Sexually active?** ☐Yes ☐No **Received HPV Vaccine?** ☐ Yes ☐ No

Hysterectomy or ovaries removed prior to 45 years of age ☐Yes ☐ No **History of PCOS?** ☐ Yes ☐ No

In utero exposure to DES ☐Yes ☐ No **Received hormone replacement therapy?** ☐Yes ☐No

Most recent bone density scan: _____ **Most recent mammogram**: _____

If menopausal, age of onset: _____ **Date of last Colonoscopy**: _____

Reproductive Medicine History

1. What are your main reproductive concerns or problems you are seeking care for? _____

_____

_____

2.**Have you ever received genetic studies?** ☐Yes ☐ No If Yes, list your Karyotype: _____

History of Pregnancies

Total number of positive pregnancy results: _____

Date of Positive Pregnancy	Type of Pregnancy (ex. Natural Cycle, IVF Transfer [fresh vs. frozen] IUI, stimulated natural cycle)	Outcome of Pregnancy

Total Number of Intrauterine insemination (IUI) Procedures: _____

Date of IUI	Outcome of IUI

Total Number of Retrieval Procedures: _____

Date of Retrieval	IVF Retrieval Outcome

Total Number of Transfer Procedures: _____

Date of Transfer	Transfer outcome

SURGICAL HISTORY

☐ No Surgical History ☐ Breast Surgery ☐ C-section ☐ Colposcopy ☐ Dilatation and curettage ☐ LEEP
☐ Hysterosalpingogram ☐ Laparoscopy ☐ Myomectomy ☐ Salpingectomy ☐ Tubal ligation ☐ Thyroid surgery
☐ Other (Indicate) _____

Surgery 1: _____
Procedure Date performed

Surgery 2: _____
Procedure Date performed

Surgery 3: _____
Procedure Date performed

Surgery 4: _____
Procedure Date performed

CURRENT MEDICATIONS

Please list all current medications including the name, frequency, and dose below:

1: _____
2: _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

If more room is needed, please attach additional form at end of packet

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MEDICAL HISTORY

History	Patient	Spouse/ Significant Other	Family (Please indicate)	*Comments
Autoimmune Thyroiditis				
Dermatomycosis's				
Fibromyalgia				
Lupus Erythematosus				
Myasthenia Gravis				
Photosensitivity				
Raynaud Disease				
Rheumatoid Arthritis				
Osteoarthritis				
Complete trisomy 21 syndrome				
Tay-Sachs disease				
Neural Tube Defect				
Fragile X Syndrome				
Sickle Cell-Hemoglobin SS				
Thalassemia				
Thrombophilia				
Muscular Dystrophy				
Mental Disability				
Other*				
Chlamydia				
Cytomegalovirus				
Gonorrhea				
Herpes				
Toxoplasmosis				
Infectious Mononucleosis				
Mycoplasma				
Rheumatic Fever				
HIV				
Other*				
Cerebrovascular incident (Stroke)				
Migraine Headaches				
Psychiatric*				
Neurologic				
Seizures				
Asymptomatic Bacteriuria				
Frequent Urinary Tract Infections				

History	Patient	Spouse/ Significant Other	Family (Please indicate)	*Comments
Kidney Stones				
Chronic Renal Disease				
Other*				
Diabetes				
Endocrinopathy				
Growth Hormone Treatment				
Maternal PKU				
Thyroid dysfunction				
Other*				
Gastric/Duodenal Ulcer				
Hepatitis A				
Hepatitis B				
Hepatitis C				
Reflux Esophagitis				
Crohn's Disease				
Diverticulitis				
H Pylori				
Anemia				
Blood Disorder				
Chronic Hypertension				
Orthostatic Hypotension				
Atrial Fibrillation				
Mitral Valve Prolapse				
Varicosities:				
History of blood transfusion(s)				
Mitral Valve Prolapse				
Other*				
Stomach Cancer				
Colorectal Cancer				
Uterine Cancer				
Breast Cancer				
Lung Cancer				
Melanoma				
Lymphoma (indicate)				
Prostate Cancer				
Bladder Cancer				
Kidney Cancer				
Leukemia				
Pancreatic				
Other*				

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Social History*(If Other/Family, please indicate)

Alcohol Addiction : ☐ No History ☐Patient ☐ Spouse/Significant Other ☐ Family* _____

- **Patient Use** (circle): Moderate/ Heavy/Occasional/ None How Many Years? _____
- **Spouse/Significant Other Use** (circle): Moderate/ Heavy/Occasional/ None How Many Years? _____

If Pregnant, what was your alcohol consumption prior to Pregnancy? (Circle): Moderate/ Heavy/Occasional/ None

History of Illicit Drug Use:

☐ No History ☐Patient ☐ Spouse/Significant Other ☐ Family* _____

- **Patient Use** (circle): Moderate/Heavy/Occasional/ None How Many Years? _____

  If Yes, please indicate which Drugs were used: _____
- **Spouse/Significant Other Use** (circle): Moderate/Heavy/Occasional/ None How Many Years? _____

  If Yes, please indicate which Drugs were used: _____

Smoking History:

☐ No History ☐Patient ☐ Spouse/Significant Other ☐ Family* _____

- **Patient Use**: Packs per Day_____ How Many Years? _____ If Quit, When? _____
- **Spouse/Significant Other Use**: Packs per Day_____ How Many Years? _____ If Quit, When? _____

Caffeine Use: ☐ No History ☐Patient ☐ Spouse/Significant Other ☐ Family* _____

- **Patient Use** (circle): Moderate/ Heavy/Occasional/ None How Many Years? _____
- **Spouse/Significant Other Use** (circle): Moderate/ Heavy/Occasional/ None How Many Years? _____

Exercise Level:

- **Patient** (circle): Moderate/Heavy/Occasional/ None
- **Spouse/Significant Other** (circle): Moderate/Heavy/Occasional/ None

Do you feel stressed (i.e. Tense, restlessness, Nervousness, anxiety, or inability to sleep)?

- **Patient** (circle): Moderate/Heavy/Occasional/ None
- **Spouse/Significant Other** (circle): Moderate/Heavy/Occasional/ None

Patient Diet: (please fill in type of Diet(s) Followed): _____

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Annual Consent for Medical Care and Services

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

A. Consent for Diagnosis, Care, and Treatment: I consent to the diagnosis, medical care and treatment that I have agreed to receive and is considered necessary or recommended by the Rosalind Franklin University Health Clinic's (RFUHC) provider(s), including treatment and services may be in-person, as well as through telehealth technologies such as telephonic, interactive audio-visual communications, and other virtual care (For example through use of the Athena Patient Portal). I understand that for services I receive using telehealth technologies may be in a different location than the provider. I understand that no guarantees have been made to me about the result of my examination or treatment.

B. Acknowledgement of Educational and Research Missions: RFUHC and their affiliates share a common mission in in advancing knowledge and discoveries through research and education with Rosalind Franklin University of Medicine and Science (RFUMS). I understand that my care will be provided within a teaching environment and the Physicians, Nurses, residents, fellows, and other health care professionals in training may be involved in my care and treatment. I also understand that my health information may be used within the within the RFUHC and its affiliates and released in accordance with the law and the RFUHC notice of Privacy Practices. I understand that my provider(s) may discuss various research opportunities that may be of interest for me and that I have the option of participating but may decline at any time.

C. Personal Property: I understand that the RFUHC and its affiliates will not be responsible for the loss, theft, or destruction of any personal property that I bring with me to RFUHC's. I release RFUHC from responsibility and liability for any personal property.

D. Photography and Recordings: I understand that I am not allowed to take pictures or use video or audio recordings of care, other patients, RFU Employees, providers, or students while within RFU facilities.

E. Language Assistance: A wide range of communication options are available based on the patient's individual needs. I understand that RFUHC utilizes qualified interpreter services and other language assistance services at no cost to me. I may request these services at any time during my visit by notifying a member of the patient care team, including my preferred language.

F. In Loco Parentis and Consent for Minors: RFUHC recognizes there may be instances when a parent/guardian is unable to accompany a minor patient to the clinic. Under Illinois law, a minor is a person who has not attained the age of 18 years and a minor cannot consent to medical treatment. A parent/guardian or person in loco parentis must consent to the treatment of a minor. The term "in loco parentis" might include an aunt or uncle or some other adult who does not have legal guardianship but who otherwise stands in the shoes of a parent. RFUHC requires the parent/guardian or loco parentis of the minor patient accompany the patient at minimum annually to provide written consent as a loco parentis designee to consent to medical consent on behalf of the minor.

HEALTH INFORMATION

A. My health information may include diagnostic information, lab tests, medications, allergies, history and assessment, treatment plans, profess or presence in treatment, clinical notes, discharge summaries and other records pertaining to my treatment. I agree that RFUHC can create recordings and images containing my health information for treatment, education and RFUHC operations as described in the RFUHC notice of Privacy Practices.

B. I understand that RFUHC and the Health System workforce adheres to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This law requires that Rosalind Franklin protect the privacy and security of its patients' treatment, contact, and financial information. Collectively, this information is referred to as your Health Information. In addition to HIPAA, there are other Federal and State laws which protect "Sensitive" health information, including health information as it relates to HIV/AIDS, behavioral or mental health, developmental disabilities, treatment for substance use disorders (alcohol and other illicit drugs), genetic

testing and counseling, sexual assault/abuse, domestic abuse of an adult with a disability, child abuse and neglect, and if as a minor, sexually transmitted illnesses, pregnancy, and birth control.

C. Treatment and Continuity of Care. As applicable and when my consent is required by law, I consent to Rosalind Franklin and its affiliates' contacting or sharing my health information with other healthcare providers to obtain information regarding my prior and current health conditions for treatment within RFUHC or as necessary for treatment, continuity of care, mandated reporting as required by law, for payment and health care operational purposes. I understand that payment purposes include disclosure of my health information to any health plan, Medicare, Medicaid, or other government program or other payer that I identify to RFUHC.

FINANCIAL CONSENTS AND ACKNOWLEDGEMENTS

A. Responsibility of Payment: I agree that I am financially responsible to and agree to pay RFUHC for services, supplies, and use of facilities which are utilized to provide my medical or behavioral health care. If I use health insurance (such as private insurance, Medicare, Medicaid, or other governmental or additional insurance plans), I authorize RFUHC to bill such insurer for all services rendered. I understand my insurance coverage may require that a portion of these charges will remain my personal responsibility such as assigned deductibles, co-payments, and charges not covered by my health insurance. I understand that my health insurance may deny payment for services for a variety of reasons. While RFUHC will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services denied by my insurer. If I claim benefits under Title XVII of the Social Security Act (Medicare), I hereby certify that the information I provide in applying for payment of such benefits is accurate.

B. As required by the **Fair Patient Billing Act**. I understand:

- I may receive separate bills from RFUHC providers for the services provide to me.
- RFUHC providers may not participate in the same insurance plans and networks. Services provided by non-participating providers in an insurance plan or network are defined as "out-of-network services". I understand I may have a greater financial responsibility for out-of-network services. I understand that it is my responsibility to contact my insurance company to determine whether RFUHC is a participating provider within my insurance plan or network.
- Any questions I have regarding my Health Insurance Coverage or benefit levels should be directed to my health plan, my employer or insurance certificate of coverage. RFUHC cannot guarantee that a service will be covered by my insurance plan.
- If I do not have health insurance or have difficulty paying my bill, RFUHC provides financial assistance options, including free care, discounted care or interest-free payments. For additional information, please contact a RFUHC financial counselors at (847) 578-8815.

MEDICAL RECORDS TO BE RELEASED

I have read, understand and agree to the statements in this Consent for Medical Care and Services agreement. I understand this consent will expire one (1) year from the date the document is signed.
Patients 12-17 years of age must sign for mental health and developmental disability, substance abuse/alcohol treatment, AIDS or HIV testing/results, sexually transmitted infections, sexual assault, pregnancy and/or birth control counseling and information.

Date	Time	Patient Name/Signature for patients 12 years of age or older
Date	Time	Signature of (Circle one): *Parent* *Legal Guardian* *Legal representative*
Date	Time	Witness (Required for Mental Health/Developmental Disabilities records in IL)

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Information Communication Authorization

Name of Patient: _____ Date of Birth: _____/_____/_____

As part of our efforts to deliver quality care, we may need to contact you at times when you are away from the Health Clinics. Some examples are returning your phone calls, reminding you of scheduled appointments, and notifying you of lab results or other events. We normally contact our patients between 8:00am and 5:00pm, Monday through Friday. In order to accommodate any request you may have, please indicate your preferences below:

Please provide the telephone number(s) that you prefer for us to use to contact you (below)	May we leave a message at this number?
Home: _____	Yes or No
Work: _____	Yes or No
Cell: _____	Yes or No

Protected Health Information Release:

We recognize that our patients often prefer to involve their family members or others in their health care. One example is when that the other person accompanies you to the examination room. At other times, you might not be readily available to express your preferences. Examples of those are when you want that other person to receive status updates while you are undergoing a procedure, to pick up prescriptions or other documents for you, or get answers to billing-related questions about your care. These events would normally involve that other person hearing or seeing some of your health information. To help us better understand your preferences in this matter, please indicate below the names of those you want to be involved in your care at times when you might not be readily available. ***Please note: RFU HC will always attempt the "patient" or "Legal Guardian" for discussions involving PHI and treatment discussions. We will utilize the approved contact as a back-up when unable to reach the patient in a timely manner.***

1._____ Relationship _____ Phone #_____

2. _____ Relationship _____ Phone #_____

3._____ Relationship _____ Phone #_____

Signature of Patient_____ Date ____/____/____

Signature of Legal Guardian (if applicable) _____ Date ____/____/____

ROSALIND FRANKLIN UNIVERSITY HealthClinics

Request for Provider to Complete Forms Policy

Dear Valued Patient,

The clinicians and staff of Rosalind Franklin University Health Clinics are committed to providing you with the highest quality care possible. It is the policy of Rosalind Franklin University Health Clinics that requests for providers to complete forms for work, or other roles that might include, but not be limited to, ability / fitness to drive or operate machinery, other fitness for duty assessments, parking disability requests etc. cannot be entertained on a first-time visit. Such requests can significantly impact the ability of Rosalind Franklin University Health Clinics to provide quality care to you, our patient.

Effective March 1, 2021, Rosalind Franklin University Health Clinics will require of an established patient – provider relationship which, for the purpose of this matter, will be defined as a minimum of three (3) visits between patient and provider. Clinicians reserve the right to exercise their professional judgement according to individual circumstances but in general as a first-time patient there should not be an expectation that paperwork is going to be completed.

If you have any questions or concerns about this change, please feel free to discuss with our Patient Service Representatives or your assigned provider. We look forward to continuing to work with you.

Sincerely,

Rosalind Franklin University Health Clinics

ROSALIND FRANKLIN UNIVERSITY HealthClinics

No Show / Same Day Cancellation Policy

Dear Valued Client,

The clinicians and staff of Rosalind Franklin University Health Clinic are committed to providing you with the highest quality care possible. It is the policy of Rosalind Franklin University Health Clinic that appointment cancellations be received by our office 24 hours prior to the scheduled appointment. We certainly understand that obstacles may arise from time to time that can interfere with your ability to keep all scheduled appointments. However, no-show and same-day cancelled appointments can significantly impact the ability of Rosalind Franklin University Health Clinic to provide quality healthcare for all our clients. Therefore, in an effort to continue to provide the highest quality care possible, we will be instituting and enforcing a no show/same-day cancellation policy.

Effective January 1st, 2023, Rosalind Franklin University Health Clinic will reserve the right to charge a fee of $50 for each appointment that is cancelled on the same day and $100 for each no showed appointment. No show/same-day cancellation fees must be paid prior to future appointments being scheduled or fulfilled.

Clinicians reserve the right to terminate services if more than (2) no shows/cancellations with less than 24 hours' notice occur within the same month or (3) total no shows occur over three consecutive months.

If you have any questions or concerns about this change, please feel free to let us know. We would be happy to discuss this with you. We look forward to continuing to work with you.

Sincerely,

Rosalind Franklin University Health Clinics

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Notice of Privacy Practices

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

INTRODUCTION

Rosalind Franklin University Health Clinics is required by law (the federal HIPAA Privacy Rule) to maintain the privacy of protected health information (PHI) and to provide you with this notice of our legal duties and privacy practices regarding PHI. We are required to abide to the terms of this notice. We may change at any time the terms of this notice for all PHI we maintain. If we do so, we will revise this notice to reflect the new terms and have it available for you upon request.

PERMITTED USES AND DISCLOSURES

At times, other federal laws and the laws of the State of Illinois impose stricter limits on the use and disclosure of PHI than the HIPAA Privacy Rule. In those cases, the HIPAA Privacy Rule states that we must follow the laws that provide you with the greater amount protection over your PHI. Subject to those stricter limits, we may use and disclose your PHI as follows:

Treatment. We may use or disclose your PHI for treatment activities of a health care provider. For example, we may use your PHI to provide medical care to you and we may disclose PHI to another physician who is providing medical care to you.

Payment. We may use or disclose your PHI for activities relating to obtaining reimbursement for the health care services you received. In addition, we may disclose your PHI for similar activities of another health care provider or a group health plan that relates to you. For example, we may use your PHI to bill you or your insurance company, as appropriate, for services rendered.

Health Care Operations. We may use or disclose your PHI for certain activities relating to the operation of the Health Clinics as a health care provider. In addition, we may disclose your PHI for those activities relating to the operation of another health care provider or a group health plan with which you have a relationship. For example, we may use and disclose your PHI for activities relating to quality assessment, training of health care professionals, fraud and abuse detection, and compliance programs.

Other Permitted Uses and Disclosures. We may use and disclose your PHI so long as certain conditions that relate to your privacy and public necessity are met:

* to **Persons Involved in Your Care or Payment of Your Care**, but you will have the opportunity to object and, if you do object, we will abide by your wishes. * to **Business Associates** who perform functions for us and who have promised in a written agreement to safeguard your PHI.
* as **Required by Law**, so long as the specifics of the use or disclosure is no more than that required by the law.
* for **Public Health Activities**, such as reporting disease, injury, and vital statistics.
* to **Report Adult Abuse, Neglect, and Domestic Violence**, under certain conditions. * to a **Health Care Oversight Agency** that oversees the health care system.
* for **Judicial and Administrative Proceedings**, so long as there is a lawful court order or other legal demand.
* for certain **Law Enforcement Purposes**, such limited PHI relating to fugitives, crime victims, suspicious deaths, crimes on our premises, and crimes in emergencies.
* certain information about **Decedents** to coroners, medical examiners, funeral directors, and organ/tissue donation entities.
* for **Research Purposes**, so long as an oversight board approves the request under strict guidelines, is preparatory work that does not leave the Health Clinics, or is about decedents.
* to **Avert a Serious Threat to Health or Safety**, as necessary under the circumstances. * for certain **Specialized Government Functions**, such as Armed Forces personnel, national security activities, correctional facilities, and government health benefit programs.
* for **Workers' Compensation** programs.
* to contact you and provide information **Useful Information**, such as appointment reminders and health-related benefits and services that may be of interest to you.

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* to contact you about the Health Clinics efforts to **Raise Funds**, but you have the right to opt out of receiving these fundraising communications.
* a **Limited Data Set**, which deletes certain information about you, so long as the PHI is only used for research, public health, or health care operations purposes and the recipient agrees in writing to safeguard your PHI.

Your Written Authorization. Other than the uses and disclosures discussed above, we will not use or disclose your PHI without your written authorization. This includes uses or disclosures made for marketing purposes, that constitute a sale of your PHI, and of most psychotherapy notes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure that occurred prior to this Health Clinic receiving your revocation.

YOUR RIGHTS

A brief summary of your rights are as follows. For additional information regarding these rights, you may contact the office listed at the end of this notice.

Access. You have the right to inspect and obtain a copy of your PHI records. To do so, you must seek access in writing. A reasonable fee may be charged for copying and postage, if applicable.

Amendment. You have the right to seek an amendment to your PHI records. To do so, you must make your request in writing. Even if the PHI record is determined to be accurate and complete, you have the right to submit a statement of disagreement.

Accounting. You have the right to obtain a list of certain disclosures that occurred regarding your PHI. To do so, you must seek your accounting in writing. Some disclosures would not be mentioned on that list, such as those associated with treatment, payment, and health care operations and disclosures you personally authorized in writing.

Further Restrictions. You have the right to seek further restrictions on how we use or disclose your PHI. To do so, you must make your request in writing. Although we are not required to agree to most of those requests, we will review them and, if we do agree, we will document it and abide by it. We are required to agree to a request to restrict a disclosure of your PHI to a health plan for payment or health care operations purposes when the PHI relates to a health care item or service for which we have been paid in full by you or by other alternative means.

Confidential Communications. You have the right to request that we communicate with you using alternative means or at alternative locations. To do so, you must make your request in writing. If the request is reasonable, we will accommodate it.

Copy of this Notice. You have the right to receive a paper copy of this notice upon request, even if you previously agreed to receive this notice electronically.

File a Complaint. You may file a complaint with us and to the U.S. Department of Health and Human Services if you believe we have violated your privacy rights and we will not retaliate against you in any way. To file a complaint with us, you should contact the office listed at the end of this notice.

Notice of Breach. You have the right to receive notifications of breaches of your unsecured PHI.

FURTHER INFORMATION

If you have any questions, desire to file a complaint, or seek further information about matters contained in this notice, you may contact:

Jeff Espina, MBA
Vice President, Clinical Services
Privacy Officer
Rosalind Franklin University Health Clinics
3471 Green Bay Road
North Chicago, IL 60064
Tel: (847) 578-8436

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