Midwest Wellness Center Associates Ltd.
Shalini Chawla MD LLC

519 N Cass Ave, Suite 204, Westmont, IL 60559; PH: (630) 541-9560; Fax: (630) 541-8381
3000 N Halsted, Suite 709, Chicago, IL 60657; PH: (773) 698-6417; Fax: (773) 698-6496
www.midwestwellnessca.com

Welcome to our practice!

Enclosed you will find information and forms that will enable our office to serve you and your family. Please review and complete these forms, and email/fax them back to us so that we can schedule your first appointment. If you have any questions, please do call us for clarification. **All of the attached forms may be signed electronically, saved on your computer. and emailed back safely**.

PLEASE DO NOT FORGET TO ACTIVATE YOUR PATIENT PORTAL SO THAT YOU MAY COMPLETE THE MEASURES ASSIGNED TO YOU REGARDING YOUR MEDICAL AND SOCIAL HISTORY AND SUBMIT IT DIRECTLY TO US THROUGH THE PORTAL

- **OFFICE POLICY, FINANCIAL POLICY, NPP, PATIENT REGISTRATION AND SIGNATURE PAGE FOR PROFESSIONAL SERVICES FORMS** — We need you, the patient, and (if the patient is less than 18 years of age) a parent to read through our office policy, financial policy, and notice of privacy practices. Please complete the registration and Professional Services Forms, **sign, and date the signature page for professional services form** indicating that you have read and understand our office and financial policy as well as the notice of privacy practices, so that we can schedule your first appointment. Please return the signature form via email or fax prior to your first appointment.

- **INSURANCE CARD** — Please **copy both front and back** of your **insurance identification card**; we need to verify insurance prior to your first visit. (If you do not wish to use insurance, please let us know — there is, of course, a different form for that!) We will also need a **copy** of your **driver's license**, to prevent identity theft.

- **CONSENTS AND AUTHORIZATIONS FOR RELEASE OF INFORMATION/ COORDINATION OF CARE FORM— Please complete, sign, and email/fax back to us the consents for treatment and release of information forms** for your therapist, Primary Care Physician, and any other person or persons with whom we should be working to coordinate care for yourself or your child. Please send these back as soon as possible. (We find that professionals tend to require some turn-around time to get records copied and sent, so please complete these and email/fax them back immediately. Don't wait until the last minute!) You can find a general Authorization of Release of Information in our patient portal and on our website and patient portal if you would like to give us consent to contact anyone else such as family, school, teachers, etc. Our **complete and abridged notice of privacy practices** can also be found on our website. We have attached the **NPP Consent form** with this packet, please **sign and date** the consent and email/fax it back to us.

- **MISCELLANEOUS FORMS:** You will also find our **fees signage form** in which the fees charged for cancellations, no show appointments, prescription refills, and review of records etc. are listed. Please review this form carefully and sign and date it. You will also find our **credit card processing form** in which you may enter your credit card information for us to keep on file for any balances due past 60 days. All patients are required to keep a credit card on file for billing purposes and will be notified prior to any charges made on their credit cards. Please refer to our **appointment policy** on when you are charged for appointments. This can be found in the patient portal, in your registration packet, as well as on our website.

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- **QUESTIONNAIRE'S PRIOR TO YOUR APPOINTMENT AND ACTIVATION OF PATIENT PORTAL ACCOUNTS —**

1. **If you are 18 and over,** please complete the **Adult Biopsychosocial History Form** prior to your appointment. Alternatively, if you have activated your patient portal account, you may complete the Adult Symptom Screener and Clinical History Form assigned to you in the patient portal which may be submitted to us through the portal for review prior to your appointment.

2. **If you are a Young Adult (15-23),** please **ALSO** fill out the **Young Adult Information form** along with the corresponding form**, Biopsychosocial History form for ages 18 and over and parents** should complete the **Parent Child and Adolescent Questionnaire for anyone under the age of 18. Alternatively**, if you have activated your patient portal, you may complete the **Adult/Child Symptom Screener** (you will be assigned one or the other) and the **Clinical History Form** assigned to you in the patient portal through which your responses may be submitted directly to us for review prior to your appointment.

3. **If you are a parent of a child,** please complete the **Parent Child and Adolescent questionnaire AND the Child Checklist of Concerns. Alternatively** you may complete the **Child Symptom Screener** and **Clinical History Form** assigned to you in the patient portal once you activate your account.

4. You may be assigned to complete additional rating scales or questionnaires through our patient portal prior to coming in for your appointment. Please complete them online so that we may review your responses prior to your appointment. **You may also update demographic and insurance information online**, so please do not lose your User ID and password for the patient portal. **If you lose or forget your user ID or password, please call us to reset them**! Don't forget to check your spam folder for the email sent to you to activate your portal account. You may also access the patient portal by going here: **https://valantmed.com/Portal/ShCa** and log on with your user ID and password.

If you need additional information, **please call us** at 630-541-9560 (Westmont) Or 773-698-6417 (Chicago) Alternatively you may **email us** at mwca@midwestwellnessca.com

— See you soon!

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PLEASE PRINT ALL INFORMATION AND RETURN PRIOR TO YOUR APPOINTMENT

PATIENT:

Name_____**Soc.Sec. #**_____**Date of Birth** _____

Address_____**City, State, Zip**_____

Email:_____

If patient is a child:

Mother's Name_____ **Father's Name** _____

Address_____ **Address** _____

_____ _____

Phone #_____ **Phone #** _____

Email_____ **Email**_____

PERSON RESPONSIBLE for PAYMENT:

Name_____ **Phone number**_____**Cell #** _____

Address_____**City, State, Zip**_____

_____**Date of Birth**_____**Soc. Sec. #** _____

Employer_____**Phone number**_____

Relationship to patient_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____

Policy Holder Name_____**Relationship to Patient** _____

Employer_____**DOB:**_____**SSN#**_____

Ins ID #_____**Group or plan #**_____

SECONDARY INSURANCE:_____

Policy Holder Name_____ **Relationship to Patient**_____

Employer_____**DOB:**_____**SSN#**_____

Ins ID #_____**Group or plan #**_____

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Nearest Relative to contact (other than parent)._____

Relationship_____ **Phone**_____

Address_____**City, State, Zip**_____

I understand that it is my responsibility to ensure that my Insurance Company has all the information needed to process my claims in a timely manner, or I shall be responsible for all payments. <u>All co-payments and deductibles will be also paid at the time of service; no balances shall be left for over 60 days. There will be collection and interest fees if balances are not paid within the 60 days. A fee will be charged for any appointments canceled without a 24-hour notice (waived for medical emergencies).</u>

I hereby consent to the release of any medical information necessary to process my claim to Shalini Chawla, MD LLC; I have read & understand both the <u>Financial Agreement and Office Policy</u>.

_____ _____

SIGNATURE of Patient/Guardian **DATE**

Therapist Name_____**Phone/Fax #** _____

Address:_____

Date of last visit_____ **Length of Contact**_____ **Release of information signed?**☐**Y**☐**N**

Primary Care Physician_____**Phone/Fax #** _____

Address:_____

Date of last visit_____**Length of Contact**_____ **Release of Information signed?**☐**Y**☐**N**

Problems that need to be addressed:_____

_____

_____

_____

I understand that it is my responsibility to arrange for my Insurance Company to have all the information needed to process my claims in a timely manner, or I shall be responsible for all payments. I hereby consent to the release of any medical information necessary to process my insurance claims to Shalini Chawla, MD LLC

_____ _____

Signature of Responsible Person **Date**

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All co-payments and deductibles will be paid at the time of service, no balances shall be left for over 60 days. There will be collection and interest fees if balance are not paid within the 60 days. A fee will be charged for any appointment canceled without a 24-hour notice and/or no show cancelation (this charge waived for medical emergencies).

I also understand that under federal HIPPA Law NO information regarding this patient will be given to anyone unless a Release of Information form has been properly filled out and signed.

If we need to contact you for appointment reminders and other correspondence, may we call your—

Patient — ☐ Home #_____ ☐ Work # _____ ☐ Cell # _____

☐ Email: _____
May we leave a message on any of these #'s? yes ☐ no ☐ — please check which #'s:

Mother — ☐ Home # _____ ☐ Work # _____ ☐ Cell #_____

☐ Email:_____
May we leave a message on any of these #'s? yes ☐ no ☐ — please check which #'s:

Father — ☐ Home # _____ ☐ Work # _____ ☐ Cell # _____

☐ Email: _____
May we leave a message on any of these #'s? yes ☐ no ☐ — please check which #'s:

I have read and understand this document, and also have read and understand the Financial Agreement, and Office Policy, and agree to the provisions therein.

_____ _____
Signature of Patient/Guardian **Date**

_____
Print Name

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— OFFICE POLICY —

We are pleased to have this opportunity to work with you. We regard health care as a collaboration between patient, doctor, and the other members of your treatment team – including family members/significant other, primary care physician and therapist. Thank you for helping us work with you to create the quality care to which we are committed.

1. **Payment** in full is required at the time of service. (In order to facilitate your access to care, we have established "Preferred Provider" relationships with several insurers; for these patients, payments will be limited to applicable co-insurance/co-payments, deductibles, and fees for "non-covered services.") Every patient is required to provide a credit card "backup' which will be billed directly for all balances owed (including insurance payment beyond the 60 days mandated by Illinois law). Co-pays for visits are due at the time of service.

2. **In an emergency**, please call our crisis line at **773-296-5380** after hours. Please contact them immediately regarding any urgent medical/psychiatric issues, including significant side-effects of medication and any significant changes in behavior (including agitation, threats of suicide or violence, or new onset of hallucinations). However, if your situation becomes physically unsafe – whether due to a medical emergency such as unexplained or excessive bleeding, loss of consciousness, possible overdose, etc., or due to dangerous psychiatric symptoms — please call "**911**" directly so that those trained personnel can provide immediate professional emergency services.

   Telephone calls between appointments are reserved for such urgent medical/psychiatric issues. Other issues, including lab results, should be addressed at your next scheduled appointment unless you and your doctor have made arrangements otherwise. A service fee will be charged for calls on non-urgent issues. This fee is currently set at $15 for the first 5 minutes (or portion thereof), and $15 for each subsequent 5-minute increment incurred. These fees are not covered by health insurance contracts, and are the patient's personal responsibility.

3. **We have no objection to scheduling sessions** for consultation with family members (e.g., parents); however, if the identified patient is not him- or herself present, these fees may not be covered by health insurance contracts, and would then be the patient's/parents' personal responsibility.

4. **If you are unable to keep your scheduled appointment**, we need 24 hours (1 day) notice. Since we usually have a "waiting list" of patients wishing a sooner appointment; reasonable prior notice of cancellations permits us to better accommodate everyone's needs. Except in cases of family/medical emergency, appointments canceled with less than 24-hours notification will be charged a service fee of $60.00. "No Shows" where no contact is made with us before the scheduled time of the appointment will be assessed $100.00 for follow up appointments and $150 for psychiatric evaluations. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. Note that repeated "No Shows" (more than 3 in a calendar year) will result in the termination of our treatment relationship. We will, as a courtesy, attempt to contact you with an appointment "reminder" – usually a confidential phone call, text, or email depending on your set preference – within the week prior to your scheduled appointments; however, scheduling and, when necessary, timely rescheduling, remain the patient's privilege and responsibility.

5. **Prescriptions** will be refilled at each appointment, following re-evaluation of your condition and medical needs, and we will provide you with at least sufficient medication and refills to extend until our scheduled next appointment. In the event of an emergency (*e.g.*, while out of town or on weekends) small amounts of medication may be available directly from a pharmacist for up to 72 hours.

Between-session telephone refills not occasioned by emergency will be subject to a $25 fee (which is not reimbursable by your health plan coverage). If such a refill is needed, please have your pharmacy **fax** the refill request to our office at 630-541-8381 (Westmont) or 773-698-6496 (Chicago) and we will attempt to respond the next business day, but please allow up to 72 hrs for prescription refill requests to be responded to. Ritalin, Focalin, Metadate, Daytrana, Concerta (methylphenidate), Dexedrine, Adderall (amphetamine salt), Vyvanse, and Benzodiazepine prescriptions are required by Illinois law to be handwritten (telephonic prescriptions and refills are not permitted), and expire 90 days following the prescription date. It is therefore imperative that patients fill these prescriptions promptly. Should the prescription expire, the expired prescription must be returned for our records, and a re-written prescription may then be obtained. The fee for such refills is $25 (which also is not reimbursable by your health plan coverage – again, this fee is waived in cases of rescheduling due to emergency). All fees must be paid prior to your next appointment.

6. **For review of past medical records and for report preparation**, there will be a service charge of $50 per 15-minute increment. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. (This does not apply to legal cases, which are billed at a separate rate.) This **does not** pertain to obtaining past records from other facilities/providers for our review if you are a new patient transferring services to us.

   For any form completion or letter requests between appointments and requests for medical records, there will be a service charge of $25. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. All fees must be paid prior to your next appointment or prior to sending medical records. Please allow up to 10 business days for requests for medical records to be transferred and 3 business days for forms or letter requests.

7. **We recognize that our patients (and their guardians) have the right to refuse treatment**, which includes the discontinuation of medications or psychotherapy. However, in order to responsibly and effectively serve you as your physicians, **we need to know of medication changes** (including discontinuation) **in advance**. If communicating with your psychiatrist in advance regarding alteration/discontinuation of prescribed medications is for any reason unfeasible (for instance, the emergence of an intolerable side effect or medication reaction), please call our office so we may alert your doctor immediately. If this policy is in any way objectionable to you, please discuss these objections with your psychiatrist before consenting to the prescription of any medication.

   Your psychotherapy is also an important component of your medical treatment, and, again, we need to be aware of any problems occurring, including any significant interruptions, so that we may continue to responsibly and effectively serve you as your physicians. We regard termination of psychotherapy as a matter best managed by client and psychotherapist in the course of their therapeutic dialogue; however, on rare occasions disagreements may arise respecting the course of therapy. If you are considering discontinuing psychotherapy against your therapist's advice, please contact your psychiatrist before finalizing termination.

8. **Notice of Privacy Policies:** Confidentiality is your right, and our duty. The privacy of all records pertaining to your treatment will be maintained securely by us. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made) and to request amendments to these records, and we will make copies available to you upon your written request. We charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with us and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

9. Your active participation is essential to our ability to provide quality services to you while minimizing fee increases. **Please assist us** by taking responsibility for this participation in your medical care. Ways that you can help include:

   - Provide advance **written consent for release of information** to those with whom you wish us to work in your treatment – primary care physicians, school personnel, spouse/family members, therapists and other consultants. Consents can be found on our website and in your registration packets as well as at your providers offices.

   - Assist us to expedite receipt of **lab values** from clinical laboratories and your other doctors' offices, and submit **questionnaires** as recommended to your child's school if necessary.

   - Contact your **insurance** company in advance to verify benefits and/or "pre-certification".

   - If treatment is sought for a minor child of divorced or separated parents (or for any person whose **guardianship** has been settled by Order of Court), our office *must* have on file a copy of the divorce decree or other Court Order specifying the terms of custody, visitation and guardianship, particularly regarding guardianship for healthcare. We must receive consent in advance for our services (both evaluation and treatment) from a party legally authorized to give consent for healthcare services. Payments of fees to our office will be the sole responsibility of the parent or guardian signing here as "responsible person" notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party. (Reimbursement from any other such party – e.g., co-parent – to the payee for payments made to us must be arranged directly by the signing "responsible person;" our office cannot bill such third parties.)

Finally, we thank you for this opportunity to work together, and hope you will be as pleased with our services as we are in providing you with the best possible psychiatric care.

Thank you for understanding our Office Policy. If you have any questions, please do not hesitate to ask us– we are here to assist you. Please sign the preceding Page 5 indicating that you have read and understand this policy and agree to abide by it.

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— FINANCIAL POLICY AND AGREEMENT —

Thank you for choosing us as your health care provider. We are committed to providing you with the best care possible. Please read the following information carefully and completely. Should you have any questions, please contact one of our staff immediately. Your clear understanding of our Financial Policy and Agreement is important to our professional relationship. **You must sign and date this form prior to the beginning of care.**

PRIMARY INSURANCE

Insurance coverage is a contract between the patient and the insurance carrier. **All co-payments, deductibles, and payments for non-covered services are due at the time of treatment.** (For your convenience, we accept MasterCard, Visa, American Express, Discover, as well as personal checks.) As a courtesy, and upon your request, we will submit billing to your primary insurer on your behalf. If you wish us to provide this service, please provide our staff with a copy of your health insurance membership card. We will contact your insurer for verification of mental health coverage, and discuss the coverage with you. (If you do not wish us to submit billing or if you are not able to provide this information to us before your first appointment, you must make payment in full at the time of service.) As above, patients or their guardians will be responsible for all charges, including any for deductibles, co-payments, and non-covered services as defined by their insurance plan. By law, the insurance carrier must remit payment or deny the insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, we may ask you to assist our office in contacting the carrier and/or in filing a complaint with the State Insurance Commissioner.

In the event that your insurance (or PPO/managed care) company indicates that your coverage has been terminated or that they need further information from you before processing claims, you agree to pay the balance due to us at that time (you will then receive the payment from your insurance company at such time as the matter is resolved).

SECONDARY INSURANCE

We are unable to directly bill secondary insurers, with the exception of patients covered by Medicare and Medicaid. Billing any other secondary insurance must be done by the patient. If you have secondary insurance for which we would otherwise be considered "in-network" or "contracted" providers, please note that any and all services provided by us must be considered "non-covered" services under such contracts. The balance due on your account, after receipt of payments from primary insurers, must be paid in full by you. We will provide you with the documentation reasonably necessary for you to file your secondary insurance claim. If multiple copies are required for any reason, we will charge you reasonable administrative and copying fees.

PREFERRED PROVIDER (PPO) / MANAGED CARE (MCO) PLANS

There are numerous insurance networks in the Chicago-land area. Our physicians are not a part of all of these networks, and, therefore, we have not agreed to accept a reduced fee from all insurance companies. Many insurance companies pay a different percentage of charges based on whether or not the physician is a part of their network. It is the responsibility of the patient to know and understand the benefits of his/her particular insurance

PAYMENT

1. Payment is expected at the time of service. For your convenience, we provide you with the Easy-Pay program, in which we charge your credit card with balances due. *Balances are not allowed to accumulate*. Should you be enrolled in a PPO or managed health care plan, we require that you make your co-payment (including deductibles and/or any co-insurance amount) at the time of each visit. **If you are more than two visits or 60 days behind in payments, NO new sessions will be scheduled until the balance of your bill, which is your responsibility, is paid.** If we can no longer service you due to lack of payment, we will assist you in finding alternative care.

2. If you prefer to file your insurance on your own or to not use insurance, payment must be made in full at the time of each visit. We will be happy to provide you with a "superbill" to assist you if you file your own insurance claims.

3. Once you reach your maximum level of insured services, further services must be paid for on the date of service.

4. While the filing of primary insurance claims is a courtesy that we extend to our patients, all charges are your

responsibility from the date services are rendered. We realize that from time to time temporary financial problems may affect timely payments of your account. If such problems do occur, please contact us promptly for assistance in management of your account — payment plans and other accommodations are generally NOT available but we will work with you based upon your financial need. **We do not offer "sliding scale fees".**

NON-COVERED SERVICES

Some of our services may not be "covered" or reimbursable under your insurance contract. This may occur because you have reached your maximum of reimbursable expenses through that insurance company; or because your insurance company does not cover the particular service provided (such as Late-Cancellation fees, No-Show fees, between-session prescription refill fees, and charges for time involved in telephone calls, record reviews, report writing, traveling to and attending a school staffing, or other services depending upon the individual insurer's contract policies). Frequently, managed care plans require a "certification of medical necessity" for particular services, and will deny payment to the physician if the MCO has not granted such "certification" (such procedures may be imposed by your insurer even when we are not members of their network.) We will make our best efforts to obtain such "certification" for our services to you, and to keep you apprised of the certification status of your care. You may continue in treatment with us regardless of "certification" status; however, payment for services requested by the patient or guardian and not covered by insurance reimbursement will become the patient/guardian's responsibility and must be paid directly by you as the services are rendered. Time required to complete billing/certification paperwork for your insurance company, reports for others (e.g., physicians, school personnel, employers), and any other paperwork that your particular insurers or others require, will be billed to you at our regular rates. We also charge a reasonable fee for the copying of records. **You are fully responsible for payment for any such "non-covered" services.**

LATE PAYMENTS

Late payments will result in additional charges, including an interest charge at the rate of 9% per annum, compounded monthly. If an outstanding balance is unpaid beyond 90 days, Shalini Chawla MD LLC, may use an attorney and/or a professional collection service to obtain the unpaid balance. Costs of any such litigation and/or collection service will also be charged to you, in addition to interest on the outstanding debt. Such additional charges and fees are not covered by insurers, and are the patient's and/or Responsible Party's sole responsibility.

RESPONSIBLE PARTY

If the patient is a minor (or is subject to guardianship under Court Order), a parent or guardian must (1) consent to treatment and (2) accept responsibility for payment for our services. In the case of divorced or separated parents – other arrangements (including Court Orders and Decrees) notwithstanding – the parent or guardian signing this form will be the party billed and agrees to be personally liable for any and all co-payments and other balances outstanding. Reimbursement (from co-parents or other parties) to the Responsible Party signing this agreement must be handled directly by the Responsible Party; our office cannot bill such third parties.

LEGAL SERVICES FOR PATIENTS

If at any point during or after treatment you, or an attorney or judge, ask our staff to become involved in legal proceedings (*e.g.*, phone calls with attorneys, letter/report writing for attorneys or the court, testimony, etc.) we will require that you provide us with a retainer of at least $500.00 before we will provide such services. The cost for these litigation-related services is billed in quarter-hour increments at $250.00/hour. Whenever the retainer credit balance falls below $500.00, payment must be made such that a "rolling" retainer credit balance of $500.00 is maintained, before further such services will be undertaken by us. No services will be undertaken until all retainers and balances are paid. We will return all unused moneys from retainers to you immediately once you have indicated in writing to us that our staff will no longer be involved in the proceedings. You may also be required to sign a separate contract, which more specifically addresses legal issues. Please note that litigation-related services provided to you as our patient are entirely distinct from Forensic Consultation as such, for which the parties must contract in advance, and which is billed at entirely different (higher) rates. In addition, particular ethical rules apply to such formal Forensic Consultation, which may, depending on your circumstances, limit our ability to provide certain services.

Thank you for understanding our Financial Policy and Agreement. If you have any questions, please do not hesitate to ask us – we are here to assist you. Please sign the preceding Page 5 indicating that you have read and understand this policy and agree to abide by it.

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Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

- When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
- When we are required to do so by lawsuits and other legal or court proceedings.
- If a law enforcement official requires us to do so.
- For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

- Your rights regarding your health information
- You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

1. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our office to arrange how to see your records. See below.
2. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
3. You have the right to a copy of this notice. If we change this notice, we will post the new version on our website, and you can always get a copy of it from our office.
4. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services.
5. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above.
6. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact us by phone at 630-541-9560 (Westmont office) or 773-698-6417 (Chicago office).

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The effective date of this notice is October 1, 2013.

Midwest Wellness Center Associates Ltd.
Shalini Chawla MD LLC

519 N Cass Ave, Suite 204, Westmont, IL 60559; PH: (630) 541-9560; Fax: (630) 541-8381
3000 N Halsted, Suite 709, Chicago, IL 60657; PH: (773) 698-6417; Fax: (773) 698-6496
www.midwestwellnessca.com

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

_____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.midwestwellnessca.com or by calling us at 630-541-9560 (Westmont office) or 773-698-6417 (Chicago office). If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative **Date**

_____ _____

Printed name of client or personal representative **Relationship to the client**

_____

Description of personal representative's authority

☐ **Copy given to the client/parent/personal representative**

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that devel-oping a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

☐ Copy accepted by client

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider (BH Provider) to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in twelve (12) months from the date of my signature below unless otherwise stated herein.**

_____ is authorized to release protected health information related to the evaluation and
(Provider Name-Please Print)

treatment of _____ _____ _____/_____/_____.
(Member Name) (Member ID#) (Date of Birth – MM/DD/YYYY)

PCP Name:_____ PCP Phone: _____

PCP Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

BH Provider Name:_____ BH Provider Phone: _____

BH Provider Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Other Name:_____ Other Phone: _____

Other Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

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Notice

Late Cancellation (< 24 hours) fee — $60.00

No Show fee for follow up appointments — $100.00,

No Show fee for Psychiatric Evaluations- $150,

Prescription Refill between Appointments fee-$25.00

NON-EMERGENT phone calls to Doctor (Please see our office policy for more information) — $15.00 / 5 min.

Forms/letters between Appointments fee- $25.00

Review of records and Report preparation- $50.00/15 min. (we do not charge to obtain and review old records).

Request for Medical Records fee - $25.00

All fees Will be charged and paid prior to scheduling next appointment.

As of October 2013

Midwest Wellness Center Associates Ltd.
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I hereby acknowledge the following payment policy of Midwest Wellness Center Associates Ltd.:

1. Payment of copays, patient portions and balances due are expected at the time that services are rendered.

2. Patients must have an updated credit card on file to cover any charges as outlined below. Please note that your card will ONLY be charged after your authorization or for failure to respond to our billing statements.

3. Midwest Wellness Center Associates Ltd will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay Midwest Wellness Center Associates Ltd for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier delays or withholds payment of its portion for more than 90 days from the date of service, both the insurance and patient portions of your account then become your responsibility. Our office policy is to automatically charge your credit card for any outstanding balance after your account becomes more than 90 days past due. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment. We will also contact you and give you the option of receiving a refund.

4. After your insurance carrier pays its portion of the claim, you may be responsible for a patient portion, due to such factors as uncovered services, copayments or unmet deductibles, as outlined in your particular insurance plan. We will send you a billing statement outlining this patient portion. You will have 30 days from the date of the billing statement to submit payment for these charges, after which time we will automatically charge your credit card for the entire amount of the patient portion.

We strongly suggest that you monitor your account and the explanation of benefit forms that you receive from your insurer. You should resolve all disputes involving patient portions and explanation of benefits directly with your insurance carrier.

_____ _____

Patient/Guardian name (PRINT) *Date*

_____ _____

Patient/Guardian Signature *Date*

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Credit Card Pre-Authorization Form

I authorize MIDWEST WELLNESS CENTER ASSOCIATES LTD/ SHALINI CHAWLA MD to keep my signature on file and to charge the credit card selected below for the following:

☐ Balance remaining after claim (s) is (are) resolved not to exceed $_____ for:

☐ This consultation only ☐ All consultations this calendar year

☐ All consultations from _____ (date) to _____ (date)

☐ Recurring charges of $_____ to be charged every _____ (frequency)

☐ From _____ (date) to _____ (date)

Charges for the following family members:

_____ _____
(authorized family member) (authorized family member)

_____ _____
(authorized family member) (authorized family member)

☐ I authorize Shalini Chawla MD, LLC. to charge my credit/debit card for all charges not paid by my insurance company within 60 days from services rendered.

Check One:

☐ Visa® ☐ American Express® ☐ MasterCard® ☐ Discover Card®

Patient Name:_____

Cardholder Name:_____

Cardholder Address:_____

City:_____ State:_____ Zip:_____

Credit Card Number:_____ Exp. Date:_____ Cvv:_____

Cardholder Signature:_____ Date:_____

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Appointment Policy

It is our intention to provide you and your children the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review policies that affect the way services are provided.

In the Office

- **Arrive early.** Please remember that all insurance requires that your insurance data be updated prior to each encounter. This usually takes a few minutes. If this is not done, your insurance may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.
- **Schedule an appointment by calling 630-541-9560 (Westmont) or 773-698-6417 (Chicago).** Walk- ins are not accepted.
- **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your visit.
- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your or your child's appointment and to minimize the need to reschedule your appointment.
- **Late arrivals (>15 minutes after scheduled appointment) will be offered the next available appointment.** In these cases, a no-show charge for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment may *or may not* be on the day the appointment was missed.
- **The no-show charge will be waived if you contact the office before your appointment.** Remember that appointments cancelled more than 24 business hours prior to when they were scheduled do *not* incur a no-show fee.
- **Appointments for additional children should be made by phone prior to coming to the office.** A $50 charge is applied for the add-on appointments. If you would like another child to be seen, please schedule appointments for *both* children *by phone* prior to coming to the office.
- **Turn off cell phones in the office and examination rooms.**
-

After-hours Call Service

- **Please limit after-hour calls to urgent issues and emergencies.** Please refer to our patient information packet for answers to common illness questions (www.midwestwellnessca.com). For refills, appointment requests, and other nonurgent matters, you may leave a message or call the office during regular hours. A charge of $25 will be applied for after-hours calls that do not lead to an office or emergency department visit. Please also do the following when using this service:
    - When leaving a message, please speak slowly.
    - Be sure to leave a callback number.
    - Disable your call block feature.
    - Follow the doctor's instructions.
- **For Emergencies, please call 911** or you may contact Advocate Illinois Masonic Hospital's Crisis Line at 773-296-5380 and speak to one of our licensed social workers or clinical psychologists available 24 hours 7 days a week.

We are here to provide the *best* care we can to you and your children should the need arise. As always, we welcome the opportunity to care for you and your children and appreciate your trust in the services we provide.