

Associates in Internal Medicine, Ltd.

211 East Chicago Avenue, Suite 1050
Chicago, IL 60611
www.aimdocs.org

Phone: (312) 944-6677 Fax: (312) 944-3346

General Internal Medicine

Joan C. Mullan, MD FACP
Michael D. Zielinski, MD FACP
Sean D. O'Connor, MD FACP
Colleen P. Doherty, MD

Endocrinology, Diabetes & Metabolism

Richard S. Crawford, MD
Emily D. Szmuiłowicz, MD
Executive Director
David R. Dolkart

Request for Confidential Communication

I, _____, hereby request *Associates in Internal Medicine, Ltd.*
(Name of Patient or Authorized Agent)

to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone:

You can contact me by phone at:

- Home
- Office
- Cell phone

Leave messages on answering machine: Yes No

Leave message with any other person: Yes No

Mail:

Contact me at the following address:

- Home
- Office

FAX:

Please *do not* contact me by FAX

Please contact me by FAX at: ____ - ____ - _____

Other Requests for Confidential Communications:

Signed:

Date:

If you are not the patient, please specify your relationship to the patient:

-- Patient's file

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To Our Patients

We are pleased to have you as our patient. Your doctor and his/her associates are internists. Internal Medicine is the broadest of the medical specialties covering the diagnosis and medical treatment of a wide range of diseases occurring in adolescents and adults of all ages. This includes diseases of the heart (cardiology), lungs (pulmonary disease), digestive system (gastroenterology), kidneys (nephrology), nervous system (neurology), blood (hematology), endocrine glands and diabetes (endocrinology), and older people (geriatrics). We do not do surgery or orthopedics (broken bones). Should you require either of these, we would refer you to the appropriate specialist for treatment.

Each of the doctors is on the faculty at the Feinberg Northwestern School of Medicine. Special areas of expertise in our group include endocrinology and metabolism (Richard Crawford MD and Emily D. Szmuilowicz, MD). More important than any title we may have, however, is the fact that we wish to function as your doctor--our aim is to help you prevent illness or deal with medical problems as they arise and relieve the burden of illness to the best of our ability.

All of us are on the staff of Northwestern Memorial Hospital. If you have any emergency, please use the Emergency Room. Tell the triage nurse that we are your doctors; she will advise us of your medical problem and we will be able to participate in the remedy.

About Your First Visit

To Complete Your New Patient Registration -- Remember to bring a photo ID (for example, your driver's license or state ID), health insurance card, and a major credit card (see Fees and Payment Policy below).

Medical History Form -- A three page form is enclosed with this letter. Please fill it out and bring it with you the day of your appointment. *We would appreciate it if you would not mail it, as the forms occasionally get lost in the mail, and we do not want to trouble you with filling out a second form.*

Parking -- We have \$10.00 coupons (*cash only*) for 4 hours of parking at the 222 E. Huron Lot. Please have exact change. You may also park for \$12 next door (directly west of the office) at the Olympia Center.

Lab Work -- All lab work for new patients is done after the physician visit. If you are a diabetic, please do NOT fast before your appointment. Follow your usual routine, taking your medications as you normally would. If you are not diabetic, please fast from midnight on if your appointment is in the morning. If it is in the afternoon, please do not eat for 8 hours prior to your appointment.

You may drink water or black coffee (with no additives), however. You should take all of your usual

medications with a sip of water. If your doctor has told you that you are going to have a cholesterol test, it is ideal to fast for 14 hours before your appointment, drinking water and taking usual medications.

Our general policy regarding lab results is to mail them to the patient within approximately 5 working days. If your tests show a major abnormality, the doctor will call you as soon as he/she receives the results. Otherwise, you may be assured that your test results will be coming in the mail within a few days. We ask that you do not call for your lab results, as it ties up the phones so badly that patients who need to get through to make appointments for urgent illnesses have great difficulty doing so.

The lab is open between 8:00 a.m. and 4:30 p.m.

Office Hours

The office is open for phone calls from 8:00 a.m. to 4:30 p.m. Monday through Friday. When you call, the phone will be answered by our automatic phone system. The doctors may be reached by speaking with their medical assistant. You may reach the appropriate assistant by dialing their extension. The following is a list of our physicians as well as their assistant's extensions.

Physician	Telephone Extension	Assistant
Dr. Joan Mullan	333	Jessica G.
Dr. Michael Zielinski	307	Barb
Dr. Sean O'Connor	336	Emily
Dr. Richard Crawford	340	Yolanda
Dr. Colleen Doherty	351	Tameitha
Dr. Emily Szmuiłowicz	318	Jessica L.

The doctors try to avoid interruptions while they are seeing patients. As a result, they tend to return phone calls either in the late morning (close to noon), or, on particularly busy days, in the late afternoon or early evening. Phone calls are returned in order of general medical urgency. Prescription refills are not considered a medical emergency. Please contact your local pharmacy for all prescription refills and they will contact us. All prescription refills will be called into the pharmacy within 24 hours after your pharmacist has contacted us with the refill request. Please be assured that the doctor or assistant will return your call at his/her earliest opportunity. Please be sure to give BOTH your work and home phone numbers, including your area code.

Fees and Payment Policy

The fee for a new patient complete history and physical exam will be submitted to your insurance company. We accept several forms of payment, including Visa, Master Card, personal checks or cash if we do not participate with your insurance company. This payment is due at the time of service. The amount of the fee depends on the length of the length of the visit and the complexity of the medical problems. Lab tests and diagnostic tests are additional.

Note that there is a no-show fee of \$100 for new patients and a no-show fee of \$50 for established patients.

Credit Card Signatures

When you sign in to be seen by your physician, we will ask for a copy of your American Express, Discover, Master Card, or Visa credit card. This copy will be kept on file for 75 days. If your insurance company has not paid your medical bill, we will bill your credit card on the 76th day. If you are on Medicare, the credit card will be used for the 20% patient responsibility amount. If you have an automatic crossover secondary plan, your American Express, Discover, Master Card, or Visa card will not be billed.

Insurance Claim Forms/Medicare

If Medicare is your primary insurance company, we will file your claim for you electronically. We do

accept Medicare assignment. However, Medicare does not pay for 20% of the fee. You will be responsible for this amount at the time of your visit.

If you have commercial insurance, we will also, as a courtesy, file your claim electronically. However, in order to keep our costs at a reasonable and customary level, we request full payment at the time of service.

Telephone Consultations

Please note that there may be a charge for phone consultations with a physician. This includes calls during the day and after hours.

Contacting Us after Hours

One of the doctors is on call every evening, weekend and holiday. To contact the doctor on call, dial 312-944-6677 or 312-649-2946. If you are sick after hours, it is best to speak to the doctor on call, even if he/she is not your usual doctor. Appropriate advice can be given without harmful delay.

In Case of Emergency

If you have an emergency causing immediate danger to life or limb, go straight to the emergency room. Locally, you can call 911, and the paramedics will come for you. They can provide emergency supportive care and transport you to the emergency room. If you live a distance from Northwestern Memorial Hospital, we still urge you to seek local help in the event of a life threatening emergency. The staff at the emergency room of your local hospital can call us and obtain useful advice, and, if appropriate, arrange for your transport to Northwestern.

A Final Word

Good medical care involves teamwork. With your cooperation, we will succeed in providing the quality of care we both desire. We are privileged to be your physicians.

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Associates in Internal Medicine Health Information Form

Name _____

Date _____

I am here for (check one)

Complete annual physical
 Follow up on old Problems

New problem(s)
 Other

In the last 6 months, have you had any unusual...

GENERAL/CONSTITUTIONAL

Fevers?	Y	N
Night sweats?	Y	N
Fatigue?	Y	N
Have you gained or lost >10lbs in 6 months?	Y	N
Sleepiness during day?	Y	N

EYES

Eye pain?	Y	N
Blurry vision?	Y	N
Change in your vision?	Y	N

HEAD & NECK

Ringling in the ears?	Y	N
Loss or change in your hearing?	Y	N
Ear pain?	Y	N
Runny nose?	Y	N
Sore throat?	Y	N
Hoarseness or voice changes?	Y	N
Nosebleeds?	Y	N

RESPIRATORY

Persistent cough?	Y	N
Sputum/Phlegm production?	Y	N
Shortness of breath?	Y	N
Coughing up blood?	Y	N
Has anyone told you that you are a loud snorer or that you have "stopped breathing" at night?	Y	N

CARDIAC

Unexplained chest discomfort?	Y	N
Palpitations?	Y	N
Unusual shortness of breath with activity?	Y	N
Shortness of breath when lying flat?	Y	N
Do you awaken from sleep with shortness of breath?	Y	N
Pain in your calves at rest or with exercise?	Y	N
Leg swelling?	Y	N

GASTROINTESTINAL

Abdominal pains?	Y	N
Nausea?	Y	N
Vomiting?	Y	N
Diarrhea?	Y	N
Constipation?	Y	N
Blood in your stool?	Y	N
Black tarry stool?	Y	N
Have your bowel habits changed?	Y	N
Loss of appetite?	Y	N
Does food get "stuck" when you swallow?	Y	N
Heartburn more than once/week?	Y	N

I have reviewed form with patient
 _____, MD

Date: _____

Associates in Internal Medicine Health Information Form

Name _____

Date _____

Preventative Health

When was your last tetanus Shot? _____ Last Pneumovax or the "pneumonia shot"? _____
 When was your last EYE exam _____ When was your last DENTAL exam? _____
 Females: When was your last mammogram? _____ PAP _____? Last period? _____
 Do you wear seatbelts? _____ Do you use helmets for biking and rollerblading? _____
 Do you have working smoke detectors in your home? _____
 Do you wear sunscreen in the sun (SPF of at least 15)? _____; Do you have a loaded gun in the home? _____; Do you practice safe sex? _____
 Do you have a designated driver after having >2 alcoholic drinks? _____

If over 50 years of age:

**Oct.-January, Do you need a flu shot? _____; Last flu shot _____
 When did you last have your stool checked for blood? _____
 Flexible sigmoidoscopy or colonoscopy? _____
 Have you been screened for Osteoporosis? _____
 Males: Last PSA (prostate screening test)? _____

Family History

	Mother	Father	Grandparents	Sibling #1	#2	#3	Children
Age							
Alive/Deceased							
Heart attack							
High Blood Pressure							
Stroke							
Diabetes							
Breast Cancer							
Colon Cancer							
Prostate Cancer							
Osteoporosis							
Thyroid Disease							

Past Medical History

Diabetes	Y	N
High Blood Pressure	Y	N
Lung Disease or Asthma	Y	N
Heart Disease	Y	N
Cancer	Y	N
Ulcers	Y	N
Depression	Y	N
High Cholesterol	Y	N
Arthritis	Y	N

Details (including when diagnosed)

Any other chronic diseases we should know about:

Past Surgical History

Surgeries	Year	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have reviewed form with patient _____, MD

Date: _____

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**Consent for Release and Use of Confidential Information and Receipt of
Notice of Privacy Practices Form**

I, _____, hereby give my consent to Associates in Internal
Medicine, Ltd. to use or disclose, for the purpose of carrying out treatment, payment, or
health care operations, all information contained 'in the patient record of

(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of
Privacy Practice provides detailed information about how the practice may use and
disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy
practices that are described in the Notice. I also understand that a copy of any Revised
Notice will be provided to me or made available upon request.

I understand that this consent is valid until it is revoked by me. I understand that I may
revoke this consent at any time by giving written notice of my desire to do so, to the
physician. I also understand that I will not be able to revoke this consent in cases where
the physician has already relied on it to use or disclose my health information. Written
revocation of consent must be sent to the physician's office.

Signed: _____

Date: _____

If you are not the patient, please specify your relationship to the patient:

— Patient's file

CONSENT FORM DEFINITIONS

“Health care operations” refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-toss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: - (a) management activities relating to HIPAA, privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder; plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) treating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not-required.

“Payment” means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of-birth, Social Security number, payment history, account number, and name and address of the physician.

“Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; the referral of a patient for health care from one health care provider or another; or, using your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

“Use” means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician’s practice that maintains such information.

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Electronic Health Records and e-Prescribing Consent Form

E-Prescribing Information and Consent

Associates in Internal Medicine, Ltd. (AIM) is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

___ I agree that AIM may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Printed Name:
Signed:
Date:

Consent for Sharing Confidential Electronic Health Information and Receipt of Notice of Privacy Practices Form

I acknowledge that this Associates in Internal Medicine, Ltd. is using an electronic health record information system (the "EHR System"), in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and

maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database and incorporating it into a data warehouse maintained by NMH.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician’s office.

<input type="checkbox"/> I agree to share electronic health information	<input type="checkbox"/> I do not agree to share electronic health information
Printed Name:	
Signed:	
Date:	

HIPAA EHR System Privacy Notice

Associates in Internal Medicine, Ltd. is using an electronic health record information system (the “EHR System”), in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH’s campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children’s Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database and incorporating it into a data warehouse maintained by NMH. The EHR System is not equipped to segregate such data as mental health, HIV, drug and alcohol abuse and genetic testing information.

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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.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how our health information is used. “HIPAA” provides penalties for cover entities that misuse personal information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this include a physical examination; and, using your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this is sending a bill to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or other persons identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your health information.

This notice is effective as of April 14th, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.