North Shore Osteopathic Healthcare LLC

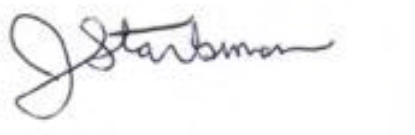
Letter of Introduction

Dear Patient,

My name is Joseph Starkman D.O. and I'd like to welcome you to my practice. I am a physician licensed to practice medicine in Illinois since 2008 and trained at the University of Chicago (North Shore) Family Medicine Residency Program. In my work I utilize conventional medical treatments, Traditional Osteopathic Medicine and Nutrition, along with Complementary and Alternative Medicine (CAM) to assist my clients in attaining optimal health.

I believe that a holistic model of treatment provides the most effective therapeutic result. I am committed to helping you change your health and life for the better in a therapeutic collaboration. I promise to give the highest quality of care to help you reach your health and life goals. I appreciate your interest in allowing me to join with you on your path toward wellness and look forward to assisting you in the process of healing and personal growth.

Sincerely yours,



Joseph Starkman D.O.

Notice of Privacy Practices

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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information", or PHI). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in Section G of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI to diagnose and provide counseling services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

2. Payment: We may use or disclose PHI so that services you receive are appropriately billed to and payment is collected from, your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing, or credentialing activities.

4. Required or Permitted by Law: We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

5. We may use and disclose PHI in connection with scheduling of appointments, including communication by telephone and leaving messages on your answering machine (if applicable) in the furtherance of scheduling appointments for your treatment, or in the furtherance of your treatment.

6. If you sign an "Authorization to Release Information", we may use and disclose PHI to family members whom you so designate.

B. Uses and Disclosures Requiring Your Written Authorization

1. Medical Records: Medical data recorded by your clinician documenting the contents of an office visit with you will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: We will not use your health information for marketing communications without your written authorization.

3. Other uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested. [*Note: State law may regulate such charges*]. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us after November 22, 2011. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the *Privacy Officer*, Joseph Starkman D.O. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or your clinician.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on November 22, 2011.

B. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we will make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office. You may also obtain any revised notice by contacting our Privacy Officer.

Financial Policies

I am committed to providing you with the best possible care. To make it possible to spend more time on items directly related to your care, I have adopted certain financial policies, which I will explain for you.

- I request that you pay your bill at the time of your visit.
- Payment by check, money order, cash and Visa or MasterCard, is accepted
- The fees I have set for my services are those considered reasonable and customary for practitioners in this area with equivalent training and experience.
- If you cannot afford the fee, or are not able to make your payment at the time of the consultation, please discuss the issue with me prior to the appointment. I am willing to negotiate other arrangements, but I want to avoid the time it takes to send multiple bills.
- I am a provider in the Blue Cross Blue Shield PPO network, but I am not a provider for any other managed care network and have no legal affiliation with any other insurance company.
- If you are a member of the Blue Cross Blue Shield PPO network, Dr. Starkman will bill BCBS on your behalf. You are responsible to pay the co-pay at the time of the appointment. If you have not yet met your deductible, you are responsible for the entire bill at the time of the appointment.
- You must provide credit card information to be kept on file by North Shore Osteopathic Healthcare, LLC to insure payment of the bill. If your insurance company has made no payment by 60 days from the date the bill was submitted, you will be required to pay the outstanding balance.
- You must take responsibility for filing the insurance claim and monitoring the status of that claim.
- Any monies received by North Shore Osteopathic Healthcare from your insurance company over & above your indebtedness will be refunded to you when your bill is paid in full.
- If your insurance company should decide, for whatever reason, that a claim once paid is now denied, you will be responsible for refunding your insurance company for that payment.
- Even if North Shore Osteopathic Healthcare files your claim, you are responsible for monitoring the status of the claim.
- I realize that temporary financial problems may affect timely payment of your account. If such problems do arise, I encourage you to contact me promptly for assistance in the management of our account.

- There will be a fee assessed of $35.00 for a returned check.
- An interest rate of 1 ½% per month will be charged on balances older than 30 days from the date you have been notified of the outstanding balance.
- Outstanding balances may be subject to additional collection fees and court costs.
- If you have out of network insurance, you are responsible to pay in full for all services provided at the time of service, regardless of whether it is covered by your insurance policy or other third party payer. I am happy to help you receive your maximum allowable benefits. I will provide you with an insurance form as a receipt with all of the usual information required for insurance reimbursement.
- If your insurance company requests additional information to verify the medical necessity of treatment, for example, I am glad to cooperate with them on your behalf and with your permission. There may, however, be a fee if the paperwork is excessive.

If you have any questions about the above policies, please do not hesitate to contact me.

I have read the financial policies of North Shore Osteopathic Healthcare, LLC. I understand these policies and agree to them.

Signature_____Date_____

Please remember the following points regarding your insurance coverage:

Your insurance policy is a contract between you, your employer & the insurance company. I am not a party to that contract.

My fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

Cancellation Policy/Credit Card Information

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee is charge for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or emergency.

Thank you for your consideration regarding this important matter.

_____ _____

Signature of Patient, Parent or Guardian Date

Please provide credit card information that can be used to charge for a no-show appointment without 24 hour notice.

Credit Card Type:

Name on Credit Card:

Credit Card #:

Security Code:

Expiration:

New Patient Health History

Name: _____Date of Birth:_____ Age: _____

STATE CURRENT HEALTH CONCERN(S):

1._____ 2._____

3._____ 4._____

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

Current Symptoms (be as descriptive as possible)

_____
_____
_____
_____

What makes it better, what makes it worse?

_____
_____

How did this condition start?

_____
_____
_____

What type of workup have you had (doctors seen, tests performed, etc.)?

_____

_____

_____

What treatments have you tried? How well have they worked?

_____

_____

_____

CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage please):

_____

_____

_____

_____

CURRENT MEDICAL CARE:

Primary Care Provider (name, practice name or location):

_____

Approximate date of last physical examination: _____ by whom? _____

Other health care professional(s) you are seeing and for what conditions: _____

_____

Would you like us to send a copy of your office visit note to your PCP or other providers?_____

ALLERGIES? (include reactions to medicines): _____

PAST MEDICAL HISTORY: Please list all major illnesses, injuries, traumas (including emotional), and surgeries w/ year

_____

_____

_____

_____

LIFESTYLE:

How many hours of sleep do you get a night? _____

How many cups or glasses do you drink per day: water:_____ milk:____ caffeinated beverages:_____

How many alcoholic beverages do you drink per week: _____Tobacco: _____ Drugs_____

How much exercise per week (what kind?) _____

What do you do for fun? _____

FAMILY MEDICAL HISTORY: (please list any conditions that run in the family, indicate if alive or deceased)

Mother_____

Father _____

Siblings_____

"REVIEW OF SYMPTOMS" Check off any of the following symptoms you have/had *recently* experienced:

GENERAL:

___ weight change
___ tired/weak
___ dizzy/fainting
___ fever/chills

HEAD:

___ headaches
___ glaucoma
___ cataracts
___ blurry vision
___ hearing aids
___ eye pain
___ hearing loss
___ noise in ears
___ earaches
___ voice change
___ runny nose
___ stuffy nose
___ nosebleeds
___ sore throats
___ swollen glands
___ painful teeth
___ bleeding gums
___ dentures
___ goiter

RESPIRATORY:

___ cough ___ cough with phlegm ___ cough with blood ___ wheezing ___ short of breath

HEART & CIRCLATION:

___ high blood pressure ___ heart races or skips beats ___ chest pain ___ short of breath after climbing steps

___ short of breath while laying in bed ___ legs swell ___ legs hurt or cramp when walking ___ varicose veins

DIGESTIVE:

☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ nausea ☐ vomiting (with blood?)

☐ diarrhea ☐ constipation ☐ excess belching or passing gas ☐ change in stool (with blood?)

☐ hemorrhoids ☐ rectal pain ☐ jaundice ☐ gallbladder pain

URINARY:

☐ burning with urination ☐ frequent urination ☐ change in urine stream (with blood?)

☐ frequent urinary infection ☐ lose urine if you cough or sneeze ☐ kidney stones

MUSCULOSKELETAL:

☐ pain in muscles or joints ☐ morning stiffness ☐ backache ☐ sciatica ☐ low back pain ☐ arthritis

☐ gout ☐ short leg ☐ wear a shoe lift ☐ scoliosis ☐ muscle spasms

NEUROLOGICAL:

☐ blackouts ☐ seizures ☐ numbness or loss of sensation ☐ tingling or "pins and needles"

☐ tremors or other involuntary movements ☐ weakness in arms or legs ☐ trouble walking

OTHER:

☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst or hunger ☐ excessive urination

☐ nervousness ☐ tension ☐ depression ☐ difficulty with memory ☐ skin changes / rash

MALE PATIENTS:

☐ urinary stream slower, smaller or split ☐ lumps or pain in testicles ☐ erection problems ☐ sores

FEMALE PATIENTS:

☐ breast tenderness or pain ☐ breast lumps ☐ nipple discharge ☐ hot flashes

☐ change in menstrual cycle, bleeding or pain ☐ vaginal sores or discharge ☐ painful intercourse

Age your periods began: _____ Number of days period lasts: _____ Date of last period _____

Number of pregnancies _____ Number of deliveries _____ Age at menopause: _____

Birth control method: _____ ;

PAIN PATTERNS CHART>>>>>>>>>>>>>>>>>>>>

On the figures provided to the right, please

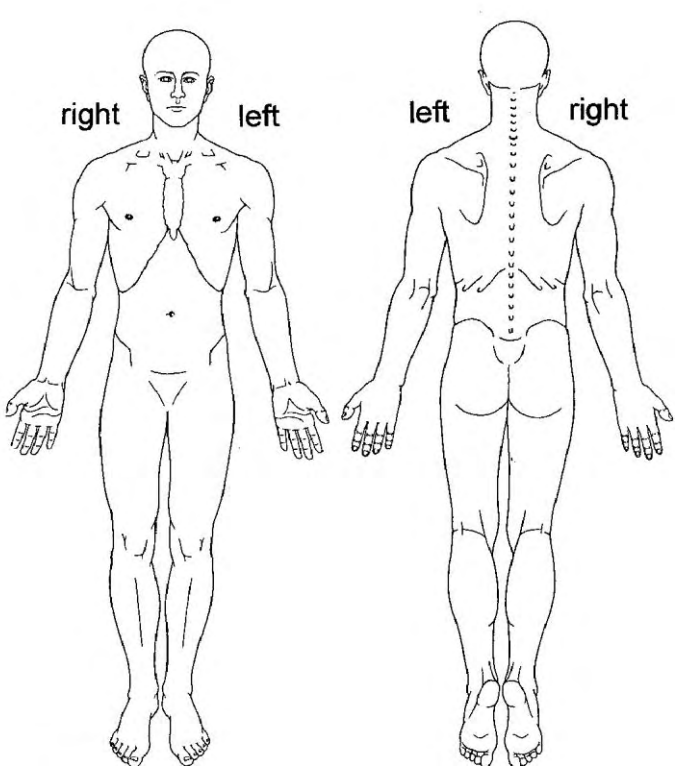
"illustrate" your areas of pain and/or numbness,

using the following key:

Moderate Pain = o o o o o

Severe Pain = x x x x x

Numbness = N N N N N



1732 1st Street
Highland Park, IL 60035
Phone: (847) 242-1210
Fax: (847) 266-8088
www.doctorstarkman.com, info@doctorstarkman.com

New Patient Information and Consent Form

Patient's name_____ M___ F___ Birth Date _____

Patient's address _____

_____

Email:_____

Telephones: home_____ work_____ cell _____

single___ married___ other___ children _____

Occupation _____

Patient's employer or school

_____

Patient's Primary Care Physician (and/or Referring Physician)

_____

Emergency Contact Info:

Name: _____ Relationship: _____ Phone: _____

Referred by:

_____

Fees: Initial Assessment/Interview: $175 HCG Monitoring : $100 Follow-up visit: $125

Informed Consent to Treatment and/or Evaluation

I hereby authorize the treatment and/or evaluation of myself (or the above named child) by Dr. Joseph Starkman (or his associate). I have discussed stated goals of treatment and/or evaluation and I understand that I have the right to ask for information regarding diagnosis, goals for treatment, and estimated length of treatment.

I have read the Patient's Rights & Responsibilities document and understand my rights & responsibilities as a patient with North Shore Osteopathic Healthcare, LLC.

I have read the Privacy Practices document and the Limits of Confidentiality document and I understand these policies and legal requirements regarding confidentiality.

I understand that notes/records taken by Dr. Starkman (or his associate) represent personal work product of my physician and as such, remain her/his sole property. I understand and agree that Dr. Starkman (or his associate) may properly retain such documents in my file according to professional standards. He/she is not required to release personal notes about my care, since these represent work product, and are not part of the formal medical record. Copies of actual records and/or typewritten reports about my care can be sent out if I provide proper written authorization, and this will be done according to professional standards. There may be a fee for preparing and sending records.

In the event of a life-threatening emergency, I can reach Joseph Starkman D.O. by calling (847) 242-1210 and leaving a message. I also understand that if a life is in imminent danger, I will not wait for Joseph Starkman, D.O. to respond. I will immediately call 911 or go to the nearest emergency room for assistance.

I have read the Financial Policies document understand the policies of North Shore Osteopathic Healthcare, LLC.

I have read the Cancellation Policy document and understand the policies of North Shore Osteopathic Healthcare, LLC regarding cancellation of appointments. I understand that the cancellation fee must be paid before any further services are rendered, unless other arrangements are made. This fee will be charged directly to the client's credit card.

I understand that this agreement becomes part of my medical record, which is accessible to the parties at will, but to no other person without written consent.

_____ _____

Signature of Patient, Parent or Guardian