# SPECIALTY ORTHOPEDIC GROUP OF MS

## NEW PATIENT MEDICAL HISTORY FORM

**Patient Name:** _____ **Height:** _____ **Weight:** _____

**Race:** ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○ Other _
○ Unknown ○ Decline to Answer

**Ethnicity:** ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer

**Preferred Language:** ○ English ○ Spanish ○ Chinese ○ Other _____

**Preferred Pharmacy:** _____

**Referral Source:** Doctor (name): _____ Other (ex. Google search): _____

## Chief Complaint

**Dominant Hand:** ○ Right ○ Left ○ Ambidextrous

**Description of Symptoms:** (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Shoulder | ○ | Right | ○ Left | Pelvis | ○ | Right | ○ Left | Neck | ○ |
| Upper Arm | ○ | Right | ○ Left | Hip | ○ | Right | ○ Left | Upper Back | ○ |
| Elbow | ○ | Right | ○ Left | Thigh | ○ | Right | ○ Left | Mid Back | ○ |
| Forearm | ○ | Right | ○ Left | Knee | ○ | Right | ○ Left | Low Back | ○ |
| Wrist | ○ | Right | ○ Left | Lower Leg | ○ | Right | ○ Left | Buttocks | ○ |
| Hand | ○ | Right | ○ Left | Ankle | ○ | Right | ○ Left | Tail Bone | ○ |
| Thumb | ○ | Right | ○ Left | Foot | ○ | Right | ○ Left | | |
| Index | ○ | Right | ○ Left | Great Toe | ○ | Right | ○ Left | | |
| Middle | ○ | Right | ○ Left | 2nd Digit | ○ | Right | ○ Left | | |
| Third | ○ | Right | ○ Left | 3rd Digit | ○ | Right | ○ Left | | |
| Little | ○ | Right | ○ Left | 4th Digit | ○ | Right | ○ Left | | |
| | | | | 5th Digit | ○ | Right | ○ Left | | |

**Pain radiates from/to:** (ex. from low back to right leg) _____

## History of Present Illness

**1. Is your problem the result of an injury or accident?**

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

**How long have the symptoms been present?** (ex. 2 days, 4 months) _____

**Describe the onset:** ○ Acute (sudden) ○ Chronic condition (>3 months)

**Onset Date:** (mm/dd/yyyy) _____

**2. Are you represented by an attorney?** ○ Yes ○ No

**Attorney Name:** _____

**Will there be any legal actions with respect to this problem?** ○ Yes ○ No

**3. Have you had a problem like this before?** ○ Yes ○ No

**Describe:** _____

_____

**4. Have you been seen in an ER for this problem?** ○ Yes ○ No

**Treating ER:** (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

 **Patient Name:** _____

## History of Present Illness (continued)

**5. Rate the pain (10 being the most pain):**

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

**6. Do the symptoms wake you from sleep?**

○ Yes ○ No

**7. Please describe the symptoms:**

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

**8. What is the timing of the symptoms?**

○ Constant ○ Intermittent (comes and goes)

**9. Is the problem getting better or worse?**

○ Getting better ○ Getting worse ○ Unchanged

**10. What makes the symptoms worse?**

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

**11. Are there any other symptoms associated with this problem?**

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

## Prior Testing / Treatment

**Have you had any prior tests for this problem?**

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

**Have you had any prior treatment for this problem?** ○ Yes ○ No

| Type of treatment | Status of symptoms after treatment (select only those that apply) | | | Date of treatment |
|---|---|---|---|---|
| Ice | ○ Improved | ○ Worsened | ○ Unchanged | |
| Heat | ○ Improved | ○ Worsened | ○ Unchanged | |
| Rest | ○ Improved | ○ Worsened | ○ Unchanged | |
| NSAIDs | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Muscle Relaxers | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Chiropractor | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Physical Therapy | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Home Exercise Program | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Surgery | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Injections | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| Bracing | ○ Improved | ○ Worsened | ○ Unchanged | _____ |
| TENS unit | ○ Improved | ○ Worsened | ○ Unchanged | _____ |

**Other/Comments:** _____

_____

_____

 **Patient Name:** _____

**Select all previous hospitalizations/surgeries:** ○ **None**

| | |
|---|---|
| ○ Aneurysm (Brain) Surgery | ○ Hysterectomy |
| ○ Aortic Bypass / Vascular Surgery | ○ LAP Band / Gastric Bypass Surgery |
| ○ Appendectomy | ○ Lumpectomy |
| ○ Cataract (Eye) Surgery | ○ Mastectomy |
| ○ Cholecystectomy (Gallbladder) | ○ Malignancy/Cancer |
| ○ Heart Surgery | ○ Stents |
| ○ Hernia Repair | |

| **Orthopedic on side:** | **Right** | **Left** |
|---|---|---|
| Arthroscopy: Knee | ○ | ○ |
| Arthroscopy: Shoulder | ○ | ○ |
| Carpal Tunnel Release | ○ | ○ |
| Rotator Cuff Repair | ○ | ○ |
| Total Hip Replacement | ○ | ○ |
| Total Knee Replacement | ○ | ○ |
| Total Shoulder Replacement | ○ | ○ |
| Spinal Surgery - Indicate Level: _____ | | |

**Other Surgery**

_____

_____

_____

**Other Orthopedic Surgery**

_____

_____

_____

## Medical Questions

**Mark all that currently apply:**

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

**Are you taking blood thinners?** ○ Yes ○ No

## Review of Systems

**Please indicate if you have experienced any of the following symptoms in the last 6 months?**

| | | | | | **None** | **Comments** |
|---|---|---|---|---|---|---|
| **1) CON** | ○ Weight Loss | ○ Loss of Appetite | ○ Fatigue | | ○ | _____ |
| **2) EYE** | ○ Blurred Vision | ○ Double Vision | ○ Vision Loss | | ○ | _____ |
| **3) ENT** | ○ Hearing Loss | ○ Hoarseness | ○ Trouble Swallowing | | ○ | _____ |
| **4) CV** | ○ Chest Pain | ○ Palpitations | | | ○ | _____ |
| **5) RS** | ○ Chronic Cough | ○ Pneumonia | ○ Shortness of Breath | | ○ | _____ |
| **6) GI** | ○ Heartburn, Ulcers | ○ Nausea, Vomiting | ○ Blood in Stool | | ○ | _____ |
| **7) GU** | ○ Painful Urination | ○ Blood in Urine | ○ Kidney Problems | | ○ | _____ |
| **8) SK** | ○ Frequent Rashes | ○ Skin Ulcers | ○ Lumps | ○ Psoriasis | ○ | _____ |
| **9) NEU** | ○ Frequent Falls | ○ Loss of Coordination | ○ Numbness | | ○ | _____ |
| | ○ Change in Bowel | ○ Change in Bladder | ○ Dizziness | | | |
| **10) PSY** | ○ Depression/Anxiety | ○ Drug/Alcohol Addiction | ○ Sleep Disorder | | ○ | _____ |
| **11) ENDO** | ○ Fever | ○ Heat or Cold Intolerance | ○ Night Sweats | | ○ | |
| **12) HEM** | ○ Easy Bleeding | ○ Easy Bruising | ○ Anemia | | ○ | _____ |

 **Patient Name:** _____

## Family History

**Have any direct relatives had any of the following disorders?** ○ **None for all**

| | | | | |
|---|---|---|---|---|
| **Father** | ○ None | ○ Diabetes | ○ Heart Disease | ○ Hypertension |
| | ○ Bleeding Problems | ○ Epilepsy | ○ Connective Tissue | ○ Muscular Dystrophy |
| | ○ Stroke | ○ Osteoporosis | ○ Rheumatoid Arthritis | ○ Cancer |
| | Comments (ex. cancer type) _____ | | | |
| **Mother** | ○ None | ○ Diabetes | ○ Heart Disease | ○ Hypertension |
| | ○ Bleeding Problems | ○ Epilepsy | ○ Connective Tissue | ○ Muscular Dystrophy |
| | ○ Stroke | ○ Osteoporosis | ○ Rheumatoid Arthritis | ○ Cancer |
| | Comments (ex. cancer type) _____ | | | |
| **Sibling** | ○ None | ○ Diabetes | ○ Heart Disease | ○ Hypertension |
| | ○ Bleeding Problems | ○ Epilepsy | ○ Connective Tissue | ○ Muscular Dystrophy |
| | ○ Stroke | ○ Osteoporosis | ○ Rheumatoid Arthritis | ○ Cancer |
| | Comments (ex. cancer type) _____ | | | |

## Social History

**Do you smoke tobacco?** ○ Daily ○ Occasionally ○ Rarely ○ Never

**Do you drink alcohol?** ○ Daily ○ Occasionally ○ Rarely ○ Never

**Marital Status:** ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

**Are you currently working?** ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

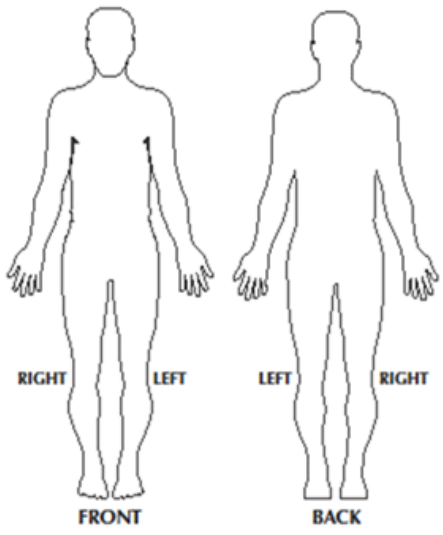
**Please list work restrictions, if any:** _____

**Occupation:** _____ **Employer:** _____ ○ **Student**

## Pain Diagram

**On the drawing below, mark an X where the pain is the worst.**
**Use the symbols below to show where you are having different kinds of pain:**

| | |
|---|---|
| Aching | ^^^^ |
| Numbness | ==== |
| Pins and Needles | oooo |
| Burning | xxxx |
| Stabbing Pain | //// |



 **Patient Name:** _____

**Do you have any allergies?** ○ Yes ○ No If Yes, please list below:

| Medication, Relevant Food, or "Seasonal" | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Latex allergy?** ○ Yes ○ No

**Please list all medications you take on a regular basis:** ○ **None**

| Medication | Dosage and Frequency (e.g. 20 mg, once/day) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Do you have a personal history of any of the following?** ○ **None**

| | | |
|---|---|---|
| ○ Aneurysm Where: _____ | ○ Emphysema | ○ Kidney Disease |
| ○ Angina (Chest Pain) | ○ Epilepsy | ○ Kidney Stones |
| ○ Arthritis Type: _____ | ○ Heart Attack | ○ MRSA Infection |
| ○ Asthma | ○ Hepatitis Type: _____ | ○ Pacemaker |
| ○ Bone or Joint Infections | ○ HIV / AIDS | ○ Phlebitis (Blood Clots) |
| ○ Cancer Type: _____ | ○ High Cholesterol | ○ Pulmonary Embolism |
| ○ Chemotherapy / Radiation | ○ Hypertension | ○ Reaction to Anesthesia Type: _____ |
| ○ COPD | ○ Hyperthyroidism | ○ Seizures |
| ○ Congestive Heart Failure | ○ Hypothyroidism | ○ Stomach Ulcers |
| ○ Diabetes Type: _____ Last A1C: _____ | | ○ Stroke / TIA |
| | | ○ Tuberculosis |

**Please list any other conditions or details of conditions marked above:**

_____

_____

_____

_____

_____

_____

_____ _____

**Signature** **Date**

specialty orthopedic group

# PATIENT INFORMATION FORM

All patient information MUST be completed in full. If you have insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the patient to settle his/her account promptly. To help us file your insurance claim correctly we must make a photocopy or scan an image of your card(s). All co-pay, co-insurance and/or deductible amounts are due at time of service.

Patient Name: _____
Last First Middle Initial Preferred Name

Social Security #: ___ - ___ - ____ Date of Birth: ___ ___ ____ Sex: M F
Month Day Year

Mailing Address: _____
Street Apt./Suite City State Zip Code

Physical Address: _____
Street Apt./Suite City State Zip Code

Race: _____ Marital Status: Single Married Divorced Widowed Seperated

Phone Numbers: ( ) ( ) ( )
Main Alternate Work

E-mail Address: _____ Place of Employment: _____

**Responsible Party Name** _____ **Relationship** _____ **Sex: M F**

**(Only if under 18) Social Security #** _____ **Date of Birth** _____

Emergency Contact Information: _____ ( )
Name Phone

Primary Physician/NP: _____ City: _____

Pharmacy: _____ City/Address: _____

Who referred you here? _____ ☐ Physician ☐ Family/Friend ☐ Other

**Patient (Responsible Party) Signature:** _____ **Date:** _____

**Is this visit due to an inury on the job?** _____ **Is Workman's Comp Insurance Involved?** _____

**Primary Insurance Coverage**

Insurance Company Name: _____

Insured Name: _____ Date of Birth: ___ ___ ____
Last First MI Month Day Year

Insured Address: _____
Street Apt./Suite City State Zip Code

ID #: _____ Group #: _____ Social Security #: ___ - ___ - ____

Relationship to Patient: _____ Insured Place of Employment: _____

**Secondary Insurance Coverage**

Insurance Company Name: _____

Insured Name: _____ Date of Birth: ___ ___ ____
Last First MI Month Day Year

Insured Address: _____
Street Apt./Suite City State Zip Code

ID #: _____ Group #: _____ Social Security #: ___ - ___ - ____

Relationship to Patient: Insured Place of Employment:

# Specialty Orthopedic Group

## GENERAL CONSENT FORM

I, the undersigned, agree to the following:

**CONSENT FOR MEDICAL TREATMENT**

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician/nurse practitioner, his assistant, designees or consultants, as may be necessary in the judgment of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

(_____) initial

**RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES**

Specialty Orthopedic Group (the "Clinic) is not responsible for valuables, including money, jewelry, glasses, dentures, documents, and other personal items.

(_____) initial

**RELEASE FROM RESPONSIBILITY**

If I should leave the Clinic against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(_____) initial

**AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

I authorize the Clinic or the Clinic's designee to disclose to payers including, but not limited to, insurers, workers compensation carriers, the Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the Clinic charges ("Third Party Payers"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payers to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or Clinic operations.

(_____) initial

**NOTICE OF PRIVACY PRACTICES**

I acknowledged that I have been given a copy of Specialty Orthopedic Groups Notice of Privacy Practices. My initials acknowledge receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(_____) iniital

**MEDICARE CERTIFICATION RELEASE**

I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

(_____) iniital

**ASSIGNMENT OF BENEFITS**

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payers. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to, billing insurance, filing petitions, filing suit in name or on behalf of the Clinic, filing proofs or claims, filing probate claims and filing grievances and

all other similar procedures. I agree to provide and sign any other documents that may be charges will be refunded as appropriate to the Third Party Payer, the patient or guarantor.

(_____) initial

**FINANCIAL RESPONSIBILITY AGREEMENT**

I understand that I am financially responsible to the Clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self-insured health plans or other third party payers are due and payable upon services based on the best estimate available as determined by the Clinic. Charges remaining on this account are payable upon demand. It is also agreed that in case of default of payment and this account is placed in the hands of a collector or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expense will be paid by the undersigned.

I agree to pay collection fees up to 33.5% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

(_____) iniital

**NON-CERTIFICATION OF SERVICES**

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance denies wither all or part of their payment on the Clinic account, I will pay the account in full upon demand.

(_____) initial

**CONSENT TO PHOTOGRAPH,, VIDEOTAPE OR OTHER IMAGING**

I authorize the Clinic to photograph, videotape, or digitally image me a appropriate for medical record identification purposes and/or to document my medical condition. I understand that these original images will be stored in a secure manner. Images that identify the patient will be released and/or used outside the Clinic only upon written authorization from myself or authorized party or as assigned by law. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(_____) initial

I have read the above consent and various releases, assignments of benefits and agreement for payment of charges and herewith execute the same voluntarily. A copy of this document shall be valid as the original.

_____

Please Print First and Last Name of the Patient (or Person Responsible)

_____

Patient Signature (or Person Responsible and Relationship)

PATIENT IS UNABLE TO CONSENT BECAUSE:

_____

_____ _____ _____

Witness Date Time

# Specialty Orthopedic Group

## AUTHORIZATION TO DISCLOSE INFORMATION

Date: _____

For information about how your medical information may be used or disclosed, please see the patient notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of Specialty Orthopedic Group. This Notice is also posted at Specialty Orthopedic Group Offices.

THIS AUTHORIZATION IS VOLUNTARY

**TO BE COMPLETED BY THE PATIENT REPRESENTIVE**

By my request, I hereby authorize Specialty Orthopedic Group to disclose information regarding my treatment, insurance issues and payment issues to the people listed below. These individuals will be asked to identify themselves and state the patient's date of birth.

| Name | Relationship | Daytime/Cell phone # |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan, health care provider or clearinghouse and that the released information, in their possession, may no longer be protected by Federal Privacy Regulation. I understand that I may withdraw my authorization in writing to the Privacy Officer of Specialty Orthopedic Group at any time, except to the extent that action has been taken in reliance on the statement. I understand that even if I do no withdraw authorization that this statement will expire 10 years from this date. I have carefully read the statement. I understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.**

_____ _____

**Signature of Patient or Patient's Representative** **Date**

Printed Name of Patient's Representative_____

Description of the Representative's Authority to Act for the patient_____

# Specialty Orthopedic Group

## Patient Financial Policy

At Specialty Orthopedic Group, we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required; the severity and complexity of the injury or illness, as well as the time spent treating you. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

**Insurance:** Billing of insurance is a courtesy we provide our patients and is not required by law. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed.

**Copayments:** Your insurance contract **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

**Deductibles and Co-Insurance:** We will verify your insurance benefits and, at the time of your appointment, you will be expected to pay a deposit towards an estimated amount owed. Following your appointment, as a **Courtesy** we will bill your insurance company, and any patient responsibility portions are to be paid upon first receipt of your patient statement. If you have questions regarding any amount due after insurance has processed your claim please contact them directly.

**Non-Covered Services:** If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. Durable Medical Equipment (DME): Some DME items may not be covered by your insurance plan and you will be asked to pay in full at the time of service. All items are new when given and cannot be returned.

**Non-Participating Insurance Plans or "Out of Network":** It is the responsibility of the patient to verify whether Specialty Orthopedic Group contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

**Referrals:** If your insurance plan requires a referral from your primary care physician or "Passport Provider" it is **Your Responsibility** to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

**Workers Compensation/Other Accident Cases:** In order for us to file a claim with your work comp or other liability carrier YOU MUST PROVIDE COMPLETE BILLING INFORMATION. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We DO NOT bill attorneys for medical services.

**Self- Pay/Uninsured:** Payment in full is required for all self- pay/uninsured patients. For new patients, a deposit of $200 is required on the day of your appointment before being seen by the provider. This covers the Office visit charge ONLY. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections will be charged separately during this time. Any fees remaining will be collected following your appointment.

**Minors of Divorced Parents and Child Custody Cases:** Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent that signs for the child will be financially responsible and any statements will be mailed directly to that parent.

**Post-Operative Surgery Charges:** Following most surgical procedures, related office visits are included and will not be charged during the 10 or 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections will be charged separately during this time.

*Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, or American Express.***Responsible parties** will be responsible for any expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned. **Please sign that you have read and agree to this Financial Policy.**

**Responsible Party Signature:** _____

**Date:** _____

**Patient Name (if different from Responsible Party):**

_____

# HIPAA Notice of Privacy Practices

Specialty Orthopedic Group

4381 South Eason Blvd, Suite 101

Tupelo, MS 38801

662-767-4200

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**TREATMENT:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**PAYMENT:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**HEALTHCARE OPERATIONS:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical student, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

**Other Permitted and Required Uses and Disclosures** will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell you protected health information without your authorization. We may not use or disclose most psychotherapy

notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.
**You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS**
The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply) –** Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.
**You have the right to request to receive confidential communications - You** have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
**You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
**You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to July 20, 2015, or six years prior to the date of the request.
**You have the right to receive notice of a breach –** We will notify you if your unsecured protected health information has been breached.
**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.
**COMPLAINTS**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this from, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of out Notice of Privacy Practices.**