SUBURBAN ORTHOPAEDIC SPECIALISTS, P.C. **PATIENT INFORMATION**

ACCOUNT #:_____ DATE:_____

PATIENT'S FIRST NAME_____LAST NAME_____MI____

Address_____City_____State____Zip_____

PHONE # (Home)_____(Cell)_____ Birthdate_____ Age_____

(Work)_____ (Email)_____

SocialSecurity # _____ Occupation:_____

Sex: M____ F____ Marital Status: S____ M____ D____ Sep.____ W____ Language: English____ Spanish____Other_____

Race: Asian____ Hispanic____ White____ Black____ Ethnicity: Latino____ Non-Latino____

Patient's Employer:_____Phone #:_____ Spouse Name:_____

If under 18 years old, please give parent's names: Mother_____ Father _____

Family physician:_____ Referring physician:_____

Address:_____ Address:_____

_____Phone:_____ Fax:_____ _____Phone:_____ Fax:_____

Pharmacy Name:_____ Address:_____Phone # _____

Reason for office visit:_____

_____

Date of injury(try to give specific date)_____How injury occurred_____

_____

Pain Level (0 - 10 : 10 being worst)_____

MEDICAL INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Insurance:_____

Subscriber's name:_____ Subscriber's name:_____

ID#_____GRP#_____ ID#_____GRP#_____

Subscriber's Address:_____City:_____State:_____Zip:_____

Subscriber's Birthdate:_____ Subscriber's Social Security #_____Sex____ Phone # _____

Subscriber's employer:_____Phone #:_____

Employer Address:_____City:_____State:_____Zip:_____

* Is this injury due to a motor vehicle accident? YES____NO____ * Is this a worker's compensation injury? YES____NO____

IF YOU ANSWERED YES TO EITHER ONE OF THE ABOVE TWO QUESTIONS, PLEASE REFER TO THE LAST PAGE OF THIS FORM TO SUPPLY US WITH ADDITIONAL INSURANCE INFORMATION.

Suburban Orthopaedic Specialists
Medical History Form

Name:_____ Age:_____ Height:_____Weight:_____

1. Past Medical History:	Yes	No	How Long (yrs)	Comments
Heart Disease	___	___	_____	
Diabetes	___	___	_____	
High Blood Pressure	___	___	_____	
Asthma	___	___	_____	
Stroke	___	___	_____	
Kidney Disease	___	___	_____	
Stomach Ulcers	___	___	_____	
Sleep Apnea	___	___	_____	
Other	___	___	_____	

2. Past Surgical History: (List any surgical procedures - include year if known)

_____
_____
_____
_____
_____

3. Past Hospitalizations:_____

_____
_____
_____

4. Allergies: (List any allergies to medication or Iodine)_____

_____

5. Medications: (List any medication you are taking, include dose and times /day if known)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Suburban Orthopaedic Specialists
Medical History Form

6. **Smoking History:**

Have you smoked at least 100 cigarettes in your entire life? Yes _____ No _____

Smoking Status:

____	Current every day smoker	____	Heavy Smoker (> 10 per day)
____	Current some day smoker	____	Light Smoker (< 10 per day)
____	Former Smoker	____	Unknown if ever smoked
____	Never a smoker	____	Smoker, current status unkown

Smoking Details: Cigarettes per day _____ Years Smoked _____

Do you use smokeless tobacco? Yes _____ No _____

Are you at risk for secondhand smoke? Yes _____ No _____

7. Alcohol Use: None ____ Occasional ____ Daily ____

Drinks per day _____

8. Family History Medical Problems:	Yes	No	Relationship to you
Heart Disease	____	____	_____
High Blood Pressure	____	____	_____
Diabetes	____	____	_____
Cancer	____	____	_____
Other	____	____	_____

9. Are you presently taking any herbal medication or supplements? Yes _____ No _____

Please List: _____

_____

_____

_____

*** Gingko Biloba, St. John's Wort or Ginseng** - Please **STOP** any of these at least 2 weeks before any scheduled surgery!

Physician Signature: _____ Date: _____

PATIENT NAME : _____ DATE : _____

Suburban Orthopaedic Specialists, P.C.

Review of Systems :

☐ **NORMAL**

GENERAL

☐ Night sweats ☐ Chills

☐ Fever ☐ Fatigue

☐ Weight loss ☐ Weight gain

SKIN

☐ Rash ☐ Itching

EYES

☐ Blurry vision ☐ Double vision

☐ Vision loss ☐ Glaucoma

EARS, NOSE, MOUTH, THROAT

☐ Hearing loss ☐ Nasal congestion

☐ Ringing in ears ☐ Nosebleeds

☐ Ear pain ☐ Mouth irritation

☐ Dizzy spells ☐ Hoarseness

MUSCULOSKELETAL

☐ Arthritis ☐ Muscle wasting

☐ Stiffness ☐ Pain

☐ Back pain ☐ Joint redness

ENDOCRINE

☐ Weight gain/loss ☐ Increased thirst

☐ Missed periods ☐ Blood sugar problems

☐ Hot flashes ☐ Cold/heat intolerance

ALLERGY / IMMUNOLOGIC

☐ Itching ☐ Immunosuppressed

☐ Watery eyes ☐ Bleeding problems

GASTROINTESTINAL

☐ Decreased appetite ☐ Difficulty swallowing

☐ Nausea ☐ Diarrhea

☐ Vomiting ☐ Constipation

☐ Heartburn ☐ Impotence

GENITOURINARY

☐ Rash ☐ Incontinence

☐ Urinary frequency ☐ Blood in urine

☐ Urinary retention ☐ Impotence

CARDIOVASCULAR

☐ Chest pain ☐ Leg swelling

☐ Heart racing ☐ Sweating

☐ Palpitations ☐ Low blood pressure

PULMONARY

☐ Cough ☐ Blood in sputum

☐ Yellow sputum ☐ Shorthness of breath

☐ Wheezing

NEURO

☐ Headache ☐ Trouble walking

☐ Weakness ☐ Balance problems

☐ Loss of sensation ☐ Shaking or tremors

☐ Speech problems ☐ Coordination problems

HEMATOLOGIC / LYMPH

☐ Bleeding problems ☐ Bruising

☐ Anemia ☐ Enlarged lymph nodes

COMMENTS:

SUBURBAN ORTHOPAEDIC SPECIALISTS, P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR MEDICARE PATIENTS

PATIENT NAME: _____ MEDICARE #: _____

"I request that payment of authorized Medicare benefits be made either to me (or on my behalf) to Suburban Orthopaedic Specialists, P.C. for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable for related services."

I understand that information will be released to:

- Billing department of the physician and/or practice

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjuster, if my claim is a work or motor vehicle injury
- Employer, if my claim is related to a work injury
- Attorney, if my claims are in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that Suburban Orthopaedic Specialists and/or their staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that Suburban Orthopaedic Specialists and/or their staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to others from the clinical billing office.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

_____ _____

Patient or Guardian Signature Witness

_____ _____

Date Date

SUBURBAN ORTHOPAEDIC SPECIALISTS, P.C.

Patient CONSENT For Use/Disclosure Of Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Suburban Orthopaedic Specialists works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Suburban Orthopaedic Specialists may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Suburban Orthopaedic Specialists has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Suburban Orthopaedic Specialists may update this "Notice of Privacy Practices". If I ask, Suburban Orthopaedic Specialists will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Suburban Orthopaedic Specialists to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Suburban Orthopaedic Specialists does not have to agree to my request. If Suburban Orthopaedic Specialists does agree to my request, I understand that Suburban Orthopaedic Specialists would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

I. Signing and dating a form that Suburban Orthopaedic Specialists can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or

II. Writing, signing, and dating a letter to Suburban Orthopaedic Specialists. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Suburban Orthopaedic Specialists does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Suburban Orthopaedic Specialist's "Notice of Privacy Practices". My signatures means that I agree to allow Suburban Orthopaedic Specialists to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

SUBURBAN ORTHOPAEDIC SPECIALISTS, P.C.
FINANCIAL RESPONSIBILITY

I understand that the physician's billing staff will file all claims for services rendered to my insurance carrier.

I, however, acknowledge that I am responsible for any balances that may be due to the physician because of:

- co-insurance or co-pay amounts
- yearly deductible amounts
- non covered services
- out of network charges
- terminated coverage
- exhausted auto benefits
- denied workers compensation claim
- no insurance coverage
- no referral obtained from primary physician
- failure to respond to insurance carrier correspondence
- failure to respond to coordination of benefits inquiry

I understand that I will receive a statement for any balance due, after the claim has been processed by my carrier. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days.

If I am unable to pay the entire amount (applies to amounts of $150.00 or more), I am responsible to immediately, on receipt of the statement, call the billing office @ 800-322-4606, to arrange a monthly payment plan, for no less than $30.00 per month.

I understand that my failure to pay my balance or arrange payments and follow the payment agreement, may result in Collection Agency action.

_____ _____

Signature of patient/responsible party Date

SUBURBAN ORTHOPAEDIC SPECIALISTS, P.C.

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.

If you have any questions about this Notice please contact our Privacy Officer who is Kathleen Huckel

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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 or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. 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 who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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.

Health Care 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 activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains

terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:
Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.
Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.
Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a

decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 health care 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 this 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 a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by an email or letter to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

3. 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 Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Kathleen Huckel at (215)-355-7220 or KathyH@SOS.NET for further information about the complaint process.

This notice was published and becomes effective on October 1, 2013**.**