Mountain View Orthopaedics
mtviewortho.com

Notice of Privacy Practices

Effective date: September 23, 2013

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.

Generally speaking, your protected health information is information about you that either identifies you or can be used to identify you and relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you. Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

Mountain View Orthopaedics and Associates, PC is required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to your protected health care information, and to notify you following a breach of your unsecured protected health information. We are required to abide by the terms of our Notice of Privacy Practices that currently is in effect. This notice replaces all prior notices and applies to all protected health information that we maintain.

If you have any questions regarding this notice, you may contact our privacy officer at:

Mountain View Orthopaedics and Associates, PC
Attention: Privacy Officer
1201A N Church St., Suite 103
Hazle Township, PA 18202
Telephone: 570-455-8544
Fax: 570-455-8554

I. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment, and health care operations

We may use and disclose your protected health information for treatment, payment, and health care operation purposes. This section generally describes the types of uses and disclosures that fall into those categories and includes examples of those uses and disclosures. Not every potential use or disclosure for treatment, payment, and health care operations purposes is listed.

1. Treatment

We may use and disclose your protected health information to help us with your treatment. We may also release your protected health information to help other health care providers treat you. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- During an office visit, practice physicians and other staff involved your care may review your medical record and share and discuss your medical information with each other.
- We may share and discuss your medical information with an outside physician with whom we are consulting regarding you.
- We may share and discuss your medical information with an outside laboratory, radiology center, or other health care facility where we have referred you for testing.
- We may share and discuss your medical information with an outside home health agency, durable medical equipment agency, or other health care provider to whom we have referred you for health care services and products.
- We may share and discuss your medical information with a hospital or other health care facility where we are admitting or treating you.

- We may share and discuss your medical information with another health care provider who seeks this information for the purpose of treating you.
- We may use a patient sign-in sheet in the waiting area that is accessible to all patients.
- We may page patients in the waiting room when it is time for them to go to an examining room. We may contact you to provide appointment reminders.

2. Payment

We may use and disclose your protected health information for our payment purposes. as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.
- Submission of a claim to your health insurer.
- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.
- Sharing your demographic information (for example, your address) with other health care providers who seek this information to obtain payment for health care services provided to you.
- Mailing you bills in envelopes with our practice name and return address.
- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.
- Providing medical records and other documentation to your health insurer to support the medical necessity of a health service.
- Allowing your health insurer access to your medical record for a medical necessity or quality review audit.
- Providing consumer reporting agencies with credit information (your name and address, date of birth, Social Security number, payment history, account number, and our name and address).
- Providing information to a collection agency or our attorney for purposes of securing payment of a delinquent account.
- Disclosing information in a legal action for purposes of securing payment of a delinquent account.

3. Health care operations

We may use and disclose your protected health information for our health care operation purposes as well as certain health care operation purposes of other health care providers and health plans. Some examples of health care operation purposes include:

- Quality assessment and improvement activities.
- Population based activities relating to improving health or reducing health care costs. Reviewing the competence, qualifications, or performance of health care professionals. Conducting training programs for medical and other students.
- Accreditation, certification, licensing, and credentialing activities. Health care fraud and abuse detection and compliance programs. Conducting other medical review, legal services, and auditing functions.
- Business planning and development activities, such as conducting cost management and planning related analyses.
- Sharing information regarding patients with entities that are interested in purchasing our practice and turning over patient records to entities that have purchased our practice.
- Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of patient grievances.

B. Uses and disclosures for other purposes

We may use and disclose your protected health information for other purposes. This section generally describes those purposes by category. Each category includes one or more examples. Not every potential use or disclosure in a category will be listed. Some examples fall into more than one category not just the category under which they are listed.

1. Individuals involved in care or payment for care

We may disclose your protected health information to someone involved in your care or payment for your care, such as a spouse, a family member, or close friend. For example, if you have surgery, we may discuss your physical limitations with a family member assisting in your post-operative care.

2. Notification purposes

We may use and disclose your protected health information to notify, or to assist in the notification of, a family member, a personal representative, or another person responsible for your care regarding your location, general condition, or death. For example, if you are hospitalized, we may notify a family member of the name and address of the hospital and your general condition. In addition, we may disclose your protected health information to a disaster relief entity, such as the American Red Cross, so that it can notify a family member, a personal representative, or another person involved in your care regarding your location, general condition, or death.

3. Required by law

We may use and disclose protected health information when required by federal, state, or local law. For example, we may disclose protected health information to comply with mandatory reporting requirements involving births and deaths, child abuse, disease prevention and control, vaccine-related injuries, medical device-related deaths and serious injuries, gunshot and other injuries by a deadly weapon or criminal act, driving impairments, and blood alcohol testing.

4. Other public health activities

We may use and disclose protected health information for public health activities, including:

• Public health reporting, for example, communicable disease reports.

• Child abuse and neglect reports.

• FDA-related reports and disclosures, for example, adverse event reports.

• Public health warnings to third parties at risk of a communicable disease or condition.

• OSHA requirements for workplace surveillance and injury reports.

5. Victims of abuse, neglect, or domestic violence

We may use and disclose protected health information for purposes of reporting of abuse, neglect, or domestic violence in addition to child abuse, for example, reports of elder abuse to the Department of Aging or abuse of a nursing home patient to the Department of Public Welfare.

6. Health oversight activities

We may use and disclose protected health information for purposes of health oversight activities authorized by law. These activities could include audits, inspections, investigations, licensure actions, and legal proceedings. For example, we may comply with a Drug Enforcement Agency inspection of patient records.

7. Judicial and administrative proceedings

We may use and disclose protected health information disclosures injudicial and administrative proceedings in response to a court order or subpoena, discovery request or other lawful process. For example, we may comply with a court order to testify in a case at which your medical condition is at issue.

8. Law enforcement purposes

We may use and disclose protected health information for certain law enforcement purposes including to:

• Comply with a legal process, for example, a search warrant.

• Comply with a legal requirement, for example, mandatory reporting of gun-shot wounds.

- Respond to a request for information for identification/location purposes.
- Respond to a request for information about a crime victim.
- Report a death suspected to have resulted from criminal activity.
- Provide information regarding a crime on the premises.
- Report information related to the commission of a crime obtained while providing emergency medical care.

9. Coroners and medical examiners

We may use and disclose protected health information for purposes of providing information to a coroner or medical examiner for the purpose of identifying a deceased patient, determining a cause of death, or facilitating their performance of other duties required by law.

10. Funeral directors

We may use and disclose protected health information for purposes of providing information to funeral directors as necessary to carry out their duties.

11. Organ and tissue donation

For purposes of facilitating organ, eye, and tissue donation and transplantation, we may use and disclose protected health information to entities engaged in the procurement , banking, or transplantation of cadaveric organs, eyes, or tissue.

12. Threat to public safety

We may use and disclose protected health information for purposes involving a threat to public safety, including protection of a third party from harm and identification and apprehension of a criminal. For example, in certain circumstances, we are required by law to disclose information to protect someone from imminent serious harm.

13. Specialized government functions

We may use and disclose protected health information for purposes involving specialized government functions including:

- Military and veterans activities. National security and intelligence.
- Protective services for the President and others.
- Medical suitability determinations for the Department of State.
- Correctional institutions and other law enforcement custodial situations.

14. Workers' compensation and similar programs

We may use and disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault. For example, this would include submitting a claim for payment to your employer's workers' compensation carrier if we treat you for a work injury.

15. Business associates

Our "Business Associates" are entities that provide services to our practice and that require access to protected health information of our patients in order to provide those services. A business associate of our practice may create, receive, maintain, or transmit protected health information while performing a function on our behalf. For example, we may share with our billing company information regarding your care so that the company can file health insurance claims and bill you or another responsible party. In addition, we may share protected health information with a business associate who needs this information to provide a service for us. For example, our attorneys may need access to protected information to provide legal services to us. Our business associates may use and disclose your protected health information consistent with this notice and as otherwise permitted by law. To protect your protected health information, we require business associates to enter into written agreements that they will appropriately safeguard the protected health information they require to provide the services they have agreed to provide.

16. Creation of de-identified information

We may use protected health information about you in the process of de-identifying the information. For example, we may use your protected health information in the process of removing those aspects which could identify you so that the information can be disclosed for research purposes. When your information has been de-identified in this way, having had all information removed that could reasonably identify that the information is yours, we may disclose this information without your authorization as it is no longer considered protected health information.

17. Incidental disclosures

We may disclose protected health information as by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.

Other possible categories: medical research.

C. Uses and disclosures with authorization

For all other purposes that do not fall under a category listed under sections I.A and I.B, we must obtain your written authorization to use or disclose your protected health information.

In addition, we are required to obtain your authorization:

- for most uses and disclosures of psychotherapy notes,
- to use and disclose your protected health information for most marketing purposes,
- to sell your protected health information

Your authorization can be revoked at any time. However, we are not able to retract uses and disclosures made with your authorization prior to the effective date of the revocation.

II. PATIENT RIGHTS

A. Further restriction on use or disclosure

You have a right to request that we restrict a use and disclosure of your protected health information, which we are otherwise permitted to make, for treatment , payment, or health care operations, to someone who is involved in your care or payment for your care, or for notification purposes.

We are not required to agree to a request for such a restriction, with one exception involving self-pay services. We must agree to a request not to disclose your protected health information to a health plan for payment or health care operation purposes if the information pertains solely to a health care item or service for which we have been paid in full by you or someone other than the health plan and the disclosure is not otherwise required by law.

To request a further restriction as outlined in this section, you must submit a written request to our privacy officer. The request must tell us: (a) what information you want restricted; {b) how you want the information restricted; and (c) to whom you want the restriction to apply.

B. Confidential communication

You have a right to request that we communicate your protected health information to you by a certain means or at a certain location. For example, you might request that we only contact you by mailor at work. We will accommodate requests for confidential communications as long as they are reasonable. To make a request for confidential communications, you must submit a written request to our privacy officer. The request must tell us how or where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

C. Accounting of disclosures

You have a right to obtain, upon request, an “accounting” of certain disclosures of your protected health information. This right is subject to limitations, such as how far back the accounting must cover and the scope of the covered disclosures. In addition, in some circumstances we may charge you for providing the accounting. To request an accounting, you must submit a written request to our privacy officer. The request should designate the applicable time period.

D. Inspection and copying

You have a right to inspect and obtain a copy of your protected health information that we maintain in a designated record set. Generally, this includes your medical and billing records. This right is subject to limitations. In certain cases, we may deny your request. We also may impose charges for the cost involved in providing copies, such as labor, supplies, and postage, as permitted by law. If your records are maintained electronically, you have the right to specify that the records you requested be provided in electronic form. We will accommodate your request for a specific electronic form or format as long as we are able to readily produce a copy in the requested form or format. If we cannot do so, we will work with you to reach agreement on an alternative readable electronic form. If you request a copy of your information electronically on a moveable electronic media (such as a USB drive-provided by patient) . . To exercise your right of access to your protected health information, you must submit a written request to our privacy officer. The request must: (a) describe the health information to which access is requested; (b) state how you want to access the information, such as inspection or pick-up of copy (c) specify any requested form or format, such as paper copy or USS drive(provided by patient).

You may also request that your protected health information be directly transmitted to another person or entity. To exercise this right, you must submit a request to our privacy officer. The request must: (a) be in writing and signed by you; and (b) clearly identify both the designated person or entity and where the information should be sent.

E. Right to amendment

You have a right to request that we amend protected health information that we maintain about you in a designated record set if the information is incorrect or incomplete. This right is subject to limitations. In certain cases, we may deny your request for an amendment. To request an amendment, you must submit a written request to our privacy officer. The request must specify each change that you want and provide a reason to support each requested change.

F. Copy of privacy notice

You have a right to receive, upon request, a copy of our Notice of Privacy Practices. Copies are available in our office reception area, on our website, or by contacting our privacy officer. Requests for special accommodation regarding the notice should be directed to our privacy officer.

G. Notification of breach

You have a right to receive timely written notice of a breach of your unsecured protected health information

III. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve the right to make any change effective for all protected health information that we or our business associate’s maintain, including information that we or our business associates created or received prior to the effective date of the change.

We will post a copy of our current notice in the waiting room for the practice. At any time, patients may review the current notice by contacting our privacy officer. Patients also may access the current notice at our web site at www.mtviewortho.com

IV. COMPLAINTS

If you believe that we have violated your privacy rights, you may submit a complaint to our privacy officer who may be contacted at:

Mountain View Orthopaedics and Associates, PC
Attention: Privacy Officer
1201A N Church St., Suite 103
Hazle Township, PA 18202
Telephone: 570-455-8544
Fax: 570-455-8554
www.mtviewortho.com

You may also submit a complaint to the Office of Civil Rights at:

Office of Civil Rights
US Department of Health and Human Services
150 S. Independence Mall West, Suite 371
Public Ledger Building, Philadelphia, PA 19106-9111
(215) 861-4441
Hotline: (800) 368-1019
Fax: (215) 861-4431 TDD: (215) 861-4440

V. LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.

You will not be retaliated against by Mountain View Orthopaedics, its staff or its Business Associates for filing a privacy complaint.

Effective Date: September 23, 2013

Mountain View Orthopaedics

Acknowledgement of Notice of Privacy Practices

I, ______________________________________ , hereby acknowledge that I have received a copy of

Mountain View Orthopaedics' Notice of Privacy Practices.

Date (MM / DD / YYYY): _____ /_____ /_________

Signature (print then sign): ______________________________________

Print patient's name if notice is received
and acknowledged by the patient's personal representative: ______________________________________

Mountain View Orthopaedics

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Office Policies

Effective April 1, 2016

No Show Visits
If you cannot keep a scheduled appointment you must notify our office at least 24 hours in advance. ALL no-show appoints without notice will be billed a $50.00 fee.

Prescription Refills
(1) Prescription refills must be requested through our Online Patient Portal. (2) Requests will be reviewed each business day. Please be aware this may result in a 1- to 3-day delay for request fulfillment.

Form Fee/Medical Record Requests
Patients will be advised regarding the amount to be paid for having form(s) or medical record requests completed. There will be a $3.00 fax fee for medical record requests faxed to another health care provider or attorney. There is a 7-10 business day turnaround timeframe for each form and medical record request.

Copays
Insurance required co-pays must be collected at appointment check-in. An exception to this policy is at the discretion of the doctor and may result in a rescheduled appointment.

Worker's Compensation and Auto Insurance
Injuries resulting from an accident the patient is responsible to provide our office information about the work comp/auto insurance carrier as well as any other insurance the patient may have. Failure to do so may result in a reschedule/cancel of your appointment. If the patient's other insurance requires a referral, it is the patient's responsibility to obtain that referral from their primary care provider before the scheduled visit to avoid a reschedule/cancellation of the appointment. In the event that Worker's Compensation/Auto denies the claim, the other insurance will be billed. Please be aware that this office does a case by case review of patients with an attorney involved or who are in active litigation before an appointment will be scheduled.

Payment
All co-payments, payment on account balances and nurse case manager payments are expected upon check-in to the office. All returned check payments will be result in an $30.00 fee charged to the patient in addition to the unpaid check amount. Returned checks patients will then be required to pay for future visits using only cash, credit card or Health Savings Account cards. Any account that is send to collections for any reason will result in that patient being discharged from the practice. An additional $25.00 fee will be assessed for an account sent to a collection agency.

Payment Plans
This office does offer multiple payment plans to assist patients meet their financial responsibility to this office. Our payment plan options can be found for review as a separate office document. Any patient placed on a payment plan, managed by this office directly, and misses one month payment may be dismissed from the practice. All explanations, provided by our patient, for a missed payment will be reviewed and determinations will be made on an individual basis.

X-ray and Lab Work
All related X-rays and lab work done prior to your appointment, films/discs and any lab results, should be brought with you to your appointment. Failure to supply this information may result in appoint reschedule/cancel at the discretion of the doctor. The results of any testing ordered by our office should be considered normal unless you are contacted by our office staff stating otherwise.

Separate Appointments
Separate appoints must be scheduled for separate injuries/problems. If you ask for a second problem to be looked at during a scheduled visit you will be asked to schedule a separate appoint for the second problem.

Privacy Practices: Please see our separate document listing our complete Notice of Privacy Practices.

There are absolutely no exceptions to the above office policies!

Acknowledgement of Office Policies

Patient's Signature: ______________________ Date (MM / DD / YYYY): ____ /____ /________

Witness Name: ______________________

Witness Signature: ______________________ Date (MM / DD / YYYY): ____ /____ /________

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Patient Information

PATIENT INFORMATION (Please Print)

Patient Name: ____________ Marital Status: ________ Date of Birth (MM/DD/YYYY): ____/____/________
Address: ______________________ Age: ______ M or F: ______
______________________ Social Security #: ____________
Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________
Email Address: ____________ Driver's License State/#: ____________
Responsible Party (if minor): ____________ Phone: ____________
Address: ______________________
____
Emergency Contact: ____________ Relationship: ____________ Phone: ____________
Family Dr.: ____________ Pharmacy: ____________
Injury Type: ◯ work ◯ auto ◯ school ◯ other **Date of Injury** (MM/MM/YYYY): ____/____/________
Attorney for this injury: ◯ yes ◯ no **Attorney Name:** ____________

PERSONAL HEALTH INSURANCE

Primary Insurance Co.: ____________
Subscriber Name: ____________
Address: ____________
____
Subscriber Soc. Sec. #: ____________
Subscriber DOB (MM/DD/YYYY): ____/____/________
Patient Relationship to Subscriber: ____________

Secondary Insurance Co.: ____________
Subscriber Name: ____________
Address: ____________
____
Subscriber Soc. Sec. #: ____________
Subscriber DOB (MM/DD/YYYY): ____/____/________
Patient Relationship to Subscriber: ____________

WORKERS COMPENSATION / AUTO INSURANCE

Insurance Co.: ____________
Billing Address: ____________
____
Adjustor Name: ____________ Contact #: ____________
Claim #: ____________ Date of Injury (MM/DD/YYYY): ____/____/________
Bodily Part Injured: ____________
____

EMPLOYMENT

Current Employer: ____________ Occupation: ____________
Address: ____________ Phone: ____________
____

Former Employer at Time of Injury: ______________________________

Address: ______________________________ Phone: ______________________

____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself an/or dependents, and that I will be bound by this signature as though the undersigned had signed the particular claim.

I ______________________ (Name of Insured) hereby authorize ______________________ (Name of Insurance Company) to pay and hereby assign directly to Mountain View Orthopaedics & Associates, PC all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Mountain View Orthopaedics & Associates, PC will be credited to my account, in accordance with the above said statement.

Authorized Signature of Subscriber ______________________ Date ____ / ____ / ________

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Medical History

Today's Date (MM / DD / YYYY) ____ /____ /________

Name ______________________________ Height ___ft ___inches Weight _____ pounds

Drug Allergies (If none, please indicate so. Attach an additional sheet if needed.)

Drug name ______________________________ Reaction ______________________________

Drug name ______________________________ Reaction ______________________________

Latex Allergy ○Yes ○No Reaction ______________________________

Poultry Allergy ○Yes ○No Reaction ______________________________

Tape Allergy ○Yes ○No Reaction ______________________________

Complications with anesthesia ○Yes ○No Complication ______________________________

Medication List (Please include all prescribed and over the counter vitamins/medications. If none, please indicate so.)

Medication ____________________ Dosage ________ Frequency ________ Reason ____________________

Medication ____________________ Dosage ________ Frequency ________ Reason ____________________

Medication ____________________ Dosage ________ Frequency ________ Reason ____________________

Medication ____________________ Dosage ________ Frequency ________ Reason ____________________

Attach an additional sheet if needed for all medications to be listed.

*** Are you under a narcotic agreement with another physician? ○Yes ○No

Surgical History (Please identify all past surgeries. If none, please indicate so.)

○Tonsils ○Appendix ○Gallbladder Hernia: ○umbilical ○inguinal ○hiatal

○Bladder ○Kidney ○Lap band ○Gastric Bypass

Males: ○Vasectomy ○Prostate

Females: ○C-Section ○Tubal ligation Mastectomy: ○R ○L ○Both

○D&C Hysterectomy: ○Complete ○Partial

Cardiac Procedure: ○Stent ○Catheterization ○Bypass ○Pacemaker

Other Procedures ____

Past Orthopaedic Surgeries (If none, please indicate so.)

Surgery ____________________ Date of Surgery (MM / YYYY) ____ /______ Surgeon ______________

Surgery ____________________ Date of Surgery (MM / YYYY) ____ /______ Surgeon ______________

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Medical History

Name ______________________ Today's Date (MM / DD / YYYY) ____ /____ /________

Medical Conditions (Please indicate all that apply.)

Lung ○Asthma ○Shortness of Breath ○Pneumonia ○COPD ○Bronchitis Other ____________

Blood Disorders ○Anemia ○Transfusions ○Clotting/Bleeding disorder Other ____________

Digestive Disorder ○Ulcer ○Acid reflux Other ____________

Kidney/Bladder Disorder ○Infection ○Kidney Stones ○Incontinence Other ____________

Metabolic Disorders ○Gout ○Jaundice ○Hepatitis Thyroid Disorder? ○hypo ○hyper

Diabetes ○No ○Yes ○Insulin dependent ○Non-insulin dependent Other ____________

Eyes/Ears/Nose/Throat ○Eyeglasses ○Contacts ○Hearing loss ○Sinusitis ○Seasonal allergies

Neuromuscular ○Convulsions ○Seizures ○Stroke ○Paralysis ○Anxiety
○Depression ○Bipolar disorder ○Fibromyalgia Other ____________

Heart Disorder ○A-fib ○Heart murmur ○Heart attack ○Angina ○Palpitations ○Cardiac Surgery
○High blood pressure ○High Cholesterol ○Mitral Valve Prolapse ○Arrhythmia

Bone/Joint Disease ○Arthritis ○Rheumatoid arthritis ○Congenital deformity Other ____________

History of Cancer ○No ○Yes When ____________ Treatment ____________

Have you ever had a pulmonary embolism (PE) or Blood Clot (DVT)? ○No ○Yes Where ____________

Are you disabled? ○No ○Yes Nature of disability ____________

Other medical conditions not listed above ____________

Family Medical History:

Mother ○Heart disease ○Stroke ○Diabetes Other ____________ ○In good health ○Deceased

Father ○Heart disease ○Stroke ○Diabetes Other ____________ ○In good health ○Deceased

Personal Habits

Alcohol Use ○No ○Yes How much? ____________

Recreational Drugs ○No ○Yes Please specify ____________

Tobacco Use ○Never used ○Yes Please specify how much daily ________ Year started smoking ______

Former smoker? ○Yes Please specify # of years smoked ______ Year quit smoking ______

Smokeless ○No ○Yes Please specify how much daily ______ Year started ______

At risk for second hand smoke ○No ○Yes

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Review of Systems

Please indicate any present complaints.

Patient Name ____________________

Constitutional Symptoms ☐ NONE

Good general health lately	◯ No	◯ Yes
Recent weight change	◯ No	◯ Yes
Fever	◯ No	◯ Yes
Fatigue	◯ No	◯ Yes
Headaches	◯ No	◯ Yes

Eyes ☐ NONE

Eye disease or injury	◯ No	◯ Yes
Wear glasses/contact lenses	◯ No	◯ Yes
Blurred or double vision	◯ No	◯ Yes

Ear/Nose/Throat/Mouth ☐ NONE

Hearing loss or ringing	◯ No	◯ Yes
Earaches or drainage	◯ No	◯ Yes
Chronic sinus problem	◯ No	◯ Yes
Nose bleeds	◯ No	◯ Yes
Chronic rhinitis	◯ No	◯ Yes
Mouth sores	◯ No	◯ Yes
Bleeding gums	◯ No	◯ Yes
Bad breath or bad taste	◯ No	◯ Yes
Sore throat or voice change	◯ No	◯ Yes
Swollen glands in neck	◯ No	◯ Yes

Cardiovascular ☐ NONE

Heart trouble	◯ No	◯ Yes
Chest pain or angina	◯ No	◯ Yes
Palpitation	◯ No	◯ Yes
Shortness of breath w/ walking or lying flat	◯ No	◯ Yes
Swelling of feet or ankles	◯ No	◯ Yes

Gastrointestinal ☐ NONE

Loss of appetite	◯ No	◯ Yes
Change in bowel movements	◯ No	◯ Yes
Nausea or vomiting	◯ No	◯ Yes
Frequent diarrhea	◯ No	◯ Yes
Painful bowel movements or constipation	◯ No	◯ Yes
Rectal bleeding or blood in stool	◯ No	◯ Yes
Abdominal pain	◯ No	◯ Yes

Genitourinary ☐ NONE

Frequent urination	◯ No	◯ Yes
Burning or painful urination	◯ No	◯ Yes
Incontinence or dribbling	◯ No	◯ Yes
Kidney stones	◯ No	◯ Yes
Male testicle pain	◯ No	◯ Yes
Female pelvic pain	◯ No	◯ Yes

Musculoskeletal ☐ NONE

Joint pain	◯ No	◯ Yes
Joint stiffness or swelling	◯ No	◯ Yes
Weakness of muscle or joints	◯ No	◯ Yes
Back pain	◯ No	◯ Yes
Cold extremities	◯ No	◯ Yes
Difficulty in walking	◯ No	◯ Yes
Muscle pain or cramps	◯ No	◯ Yes
Gout	◯ No	◯ Yes

Integumentary (skin, breast) ☐ NONE

Rash or itching	◯ No	◯ Yes
Change in skin color	◯ No	◯ Yes
Suspicious lesion	◯ No	◯ Yes

Neurological ☐ NONE

Frequent/recurring headaches	◯ No	◯ Yes
Light headed or dizzy	◯ No	◯ Yes
Convulsions or seizures	◯ No	◯ Yes
Numbness/tingling sensations	◯ No	◯ Yes
Tremors	◯ No	◯ Yes
Paralysis	◯ No	◯ Yes
Head injury	◯ No	◯ Yes
Migraines	◯ No	◯ Yes

Psychiatric ☐ NONE

Memory loss	◯ No	◯ Yes
Nervousness	◯ No	◯ Yes
Depression	◯ No	◯ Yes
Insomnia	◯ No	◯ Yes
Confusion	◯ No	◯ Yes

Endocrine ☐ NONE

Glandular or hormone problems	◯ No	◯ Yes
Excessive thirst	◯ No	◯ Yes
Excessive urination	◯ No	◯ Yes

Hematologic/Lymphatic ☐ NONE

Slow to heal after cut	◯ No	◯ Yes
Bleeding tendency	◯ No	◯ Yes
Bruising tendency	◯ No	◯ Yes
Anemia	◯ No	◯ Yes
Phlebitis	◯ No	◯ Yes
Past transfusion	◯ No	◯ Yes
Enlarged glands	◯ No	◯ Yes

Respiratory ☐ NONE

Chronic or frequent coughs	◯ No	◯ Yes
Spitting up blood	◯ No	◯ Yes
Shortness of breath	◯ No	◯ Yes
Wheezing	◯ No	◯ Yes

Allergies ☐ NONE

Drug reactions	◯ No	◯ Yes
Hives	◯ No	◯ Yes
Seasonal	◯ No	◯ Yes
Latex	◯ No	◯ Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.

Patient's Signature: ____________________ Date (MM/DD/YYYY): ____ /____ /________

Physician's Signature: ____________________ Date (MM/DD/YYYY): ____ /____ /________

Authorization for release of health information

Patient Name ______________________ Date of Birth (MM/DD/YYYY) ____ /____ /______

Address ______________________ Telephone ____________

Provider or facility authorized to release information ______________________

Address ______________________

Person or entity authorized to receive information ______________________

Address ______________________

Type of Record ○Inpatient ○Outpatient ○Emergency Room ○Physician's Office ○Radiology Films ○Other ____________

Date(s) of Treatment ______________________

Description of information to be used or disclosed: ○Entire Record ○Other ____________

Special Records: The medical records to be released will not include records of drug and alcohol abuse program treatment, mental health treatment or HIV/ AIDS related information records unless I have specifically authorized the release of such information by my initials below.

_____ Include drug and alcohol records _____ Include mental health record _____ Include HIV Records

Purpose of Release of Information ○ Personal Use ○ Medical Treatment/Management ○ Legal Proceedings ○ Employment Related ○ Insurance Related ○ Other ______________________

1. This authorization will expire ○ Date (MM/DD/YYYY) ____ /____ /______ ○Event ____________
   Unless otherwise specified, this authorization will expire one year after the date of this request.
2. I understand that I may revoke this authorization in writing at any time. I understand that revocation will not have any affect on actions that any health care provider took before they received the revocation.
3. This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.
4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

Signature of patient or personal representative: ______________________

Print Name: ______________________ Date (MM/DD/YYYY): ____ /____ /______

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Authorization to speak with or contact the following

Please list the name(s), relationship and contact information of any person(s) you allow us to speak with or contact regarding your medical condition, treatment, test and/or account matters. Any changes to the person(s) listed below must be received by this office in writing from our patient including an original signature and date.

Please also sign and date below in both areas as indicated.

Authorized Contacts

1. Name ______________________ Relationship ______________________
   Contact Phone Numbers Home ______________ Cell ______________________
   Contact Email ______________________

2. Name ______________________ Relationship ______________________
   Contact Phone Numbers Home ______________ Cell ______________________
   Contact Email ______________________

3. Name ______________________ Relationship ______________________
   Contact Phone Numbers Home ______________ Cell ______________________
   Contact Email ______________________

Patient's Signature: ______________________ **Date (MM / DD / YYYY):** ____ / ____ / ________

Patient Contact Preferences

Please list all means of contact that you authorize this office to leave messages with regards to your condition and account. Any change to the information listed below must be received by this office in writing from our patient including an original signature and date.

Home phone ______________________

Cell phone ______________________

Email address ______________________

Patient's Signature: ______________________ **Date (MM / DD / YYYY):** ____ / ____ / ________

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Patient Payment Plans

Effective April 1, 2016

As a courtesy, this office offers various payment plans to our patients. These plans are offered to help you meet your financial responsibilities for services rendered at our office.

1. Patients may make monthly payments directly to our office for account balances up to $200.00 (cash, check or credit card). A finance charge of 18% APR will be assessed and added to your account balance until paid in full when you choose this option.
2. Patients may supply a credit card and complete a **Credit Card Authorization Form** for account balances up to $500.00. There is a choice of monthly draw, in the specified amount listed on the authorization form ($50.00 monthly draw minimum), on the 15th or 30th of each month. A **quarterly fee of $5.00** will be assessed to the account balance when you choose this option.
3. Patients may apply for third party financing with a **CareCredit** plan, subject to credit approval. Applications are to be submitted independently by our patients at **800-365-8295** or online at **carecredit.com**. A paper application is required for individual patients age 18 to 21 years of age. These applications can be obtained at our office locations.

    - **Plan #1** (Standard Plan)
      An interest rate of 26.99% APR for any purchase made under $200.00 for the life of the balance.
    - **Plan #2** (Promotional)
      A 0% APR plan, which requires the balance to be paid in full in 6 months. If the balance is not paid in full by the 6 month mark, an interest rate of 26.99% will be applied from the **purchase** date. A $200.00 minimum purchase amount is required when this plan is chosen.
    - **Plan #3** (Promotional)
      A fixed 14.9% APR plan, which charges the listed APR over a 24-, 36- or 48-month period. A $1,000.00 minimum purchase amount is required when this plan is chosen. If the purchase amount is in excess of $2,500.00 then a 60 month payment period is also available with this plan.

All accounts are to be settled in full, or have one of the above payment options implemented,
30 days from the date of billing.